BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:	)	
	)	
	)	MBC No. 12-2009-197864
Suprabha Jain, M.D.	)	
	)	
Physician's & Surgeon's Certificate No. A 67699	)	**ORDER GRANTING STAY**
	)	
	)	(Gov't Code Section 11521)
	)	
Respondent	)	

Robert W. Hodges, Attorney at Law, on behalf of Suprabha Jain, M.D., has filed a Request for Reconsideration of the Decision in this matter with an effective date of March 28, 2014.

Execution is stayed until April 7, 2014.

This stay is granted solely for the purpose of allowing the Board to review and consider the Petition for Reconsideration.

DATED: March 28, 2014

A. Renee Threadgill
Chief of Enforcement
Medical Board of California

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:	
SUPRABHA JAIN, M.D.,	Case No. 12-2009-197864
Physician and Surgeon's Certificate No. A 67699	OAH No. 2012070765
Respondent.	

DECISION AFTER NONADOPTION

Administrative Law Judge Ruth S. Astle, State of California, Office of Administrative Hearings, heard this matter in Oakland, California on May 13, 14, 15, 16 and June 19 and 20, 2013.

Vivian Hara, Deputy Attorney General, represented complainant.

Respondent Suprabha Jain, M.D., was present and represented by Robert W. Hodges, Attorney at Law.

Submission of the matter was deferred for receipt of final arguments, which were received and considered. The matter was submitted on August 21, 2013.

Panel A of the Medical Board of California (Board) declined to adopt the proposed decision issued on September 20, 2013, and issued an Order of Non-Adoption of Proposed Decision on November 14, 2013. On January 3, 2014, the Board issued a Notice of Hearing for Oral Argument, and fixed the date for argument on February 6, 2014. The Panel, having read and considered the entire record, including the transcripts and the exhibits, and having considered the written and oral arguments presented by respondent and complainant, hereby makes and enters this decision on the matter.

FACTUAL FINDINGS

1. Complainant Kimberly Kirchmeyer made this accusation in her official capacity as the Interim Executive Director of the Board.

2. On March 5, 1999, Physician and Surgeon's Certificate No. A 67699 was issued by the Board to Suprabha Jain, M.D. (respondent). Respondent's certificate will expire March 31, 2015, unless renewed.

Respondent has not been the subject of prior disciplinary action.

Gross Negligence/Negligence/Incompetence -Patient K.S.

3. K.S. first consulted respondent at Mt. Diablo Wellness Center, Inc. (MDI) on January 4, 2009. K.S. had issues with anxiety, depression, and pain since she was 28 years old. She had consulted an acupuncturist and a chiropractor. She was also a patient of an integrative pain management clinic in Concord, California. Respondent was never K.S.'s primary care physician. K.S. suffered from chronic neck and low back pain; her weight was 210 pounds at the time she first consulted respondent. She also complained of always being cold and sleeping 14 hours a day. She indicated on her MDI patient information sheet that her reason for consulting respondent was "sweats and muscle spasm."

4. K.S. reported that in the previous year, she had decided to reduce or eliminate a number of drugs she was taking for her medical conditions. Her prescribed drugs included Advair, albuterol, Xanax, Dilaudid, Oxycodone, Effexor, Abilify, Klonopin, fentanyl patches, and a stool softener. She had been reducing or eliminating the drugs by herself without medical supervision. She stopped using all prescribed medications except Klonopin and fentanyl patches at the time she consulted respondent.

5. When K.S. began suffering from sweats and nausea, her son recommended respondent's clinic. K.S.'s mother had been respondent's patient previously and had $5,000 in unapplied deposits reserved at MDI. K.S. called MDI and was able to make an appointment with respondent for the next day, January 4, 2009. K.S. filled out a patient information sheet and was examined by respondent. Respondent recognized that K.S. was suffering the effects of narcotics/controlled substance withdrawal.

6. Respondent developed a "medical model" form for intake history and physical. On January 4, 2009, K.S. filled out the first page of a patient information form; the second page was left blank. Respondent recorded a brief medical history of K.S. in her progress notes and recorded vital signs. After this initial intake form, there are no other vital signs recorded. Respondent had laboratory tests performed on K.S., including a complete blood count (CBC), urinalysis, chemistry panel, and toxicology screen. All laboratory values were within normal limits, and the toxicology screen was negative, even for benzodiazepines, such as Klonopin, or opiates such as fentanyl. Respondent did not repeat the laboratory tests.

7. On January 5, 2009, K.S. signed her payment agreement and had the program of treatment explained to her, which included live blood cell analysis, "full body" detoxification, Ayurvedic yoga therapy, healthy cooking, meditation, bioresonance sessions, and IV vitamins and chelation as needed. K.S. was provided with some material describing the purposes behind the therapies, general principles and guidelines of Ayurvedic therapies, a healthy cooking food menu, the Ayurvedic toxin-elimination regimen, and live blood evaluation pictorial worksheets. Respondent filled out a history and physical form which

included information about the patient's current medications, which were fentanyl patch and Klonopin; and her current symptoms, which included excessive sweating, anxiety, severe neck pain, overweight, sleeplessness, and drug withdrawal. No vital signs were recorded on the physical examination portion. This form included a nutritional intake evaluation, where the patient's usual diet was recorded.

8. Respondent described her mode of medical practice as primarily including a spiritual aspect, where the patient's mind, body, and spirit are involved. She developed a body constitution questionnaire for this aspect, where the patient assesses his or her general state of mind and body. K.S filled out this form on January 5, 2009. Respondent believes this aspect of treatment requires connecting and bonding with the patient and that there are no templates for documenting this type of work. On January 5, 2009, K.S. presented respondent with a schedule that the patient wanted to use for tapering off the Klonopin and fentanyl. On that same day, K.S. received a colon cleansing assessment in which a severely impacted bowel was found and colonic irrigation was scheduled. K.S. also received a therapeutic breathing treatment that day and again on January 7 and 9, 2009. Respondent discontinued the stool softener and prescribed Libidex cream and other herbal medications.

9. K.S. enrolled in respondent's wellness program and not in a pain management program or for assistance with drug withdrawal. Both K.S. and respondent were aware that K.S. was decreasing her drug regimen. Respondent saw her role as supporting the patient's withdrawal, not directing it. Respondent did not consult with the patient's pain management physicians or obtain medical records from the patient's prescribers.

10. K.S. saw respondent on a daily basis during this time. Respondent disimpacted the patient's bowel and recommended more fiber and warm water intake in addition to herbal remedies.

11. K.S. continued a variety of treatments over a two-week period. K.S. was experiencing nausea, and weakness with fatigue. By January 14, 2009, respondent noted K.S. was tired and dehydrated, and she was given intravenous (IV) vitamin treatment. On January 16, 2009, K.S. reported extreme fatigue, insomnia, and diarrhea. Respondent again administered IV treatment with a vitamin and mineral solution.

12. On January 17, 2009, respondent made a house call because K.S. was too weak to go into the clinic. Respondent recommended fluids and supplements with a slowly advancing vegetable diet, as well as an over-the-counter anti-emetic. Respondent noted that K.S.'s drug dependence/withdrawal was still fluctuating, but with more "better" moments. Respondent documents a "long talk" with K.S. about her past traumas and emotional stressors.

13. Respondent saw K.S. at MDI on January 20, 2009. Respondent notes loss of weight, night sweats, and loss of sleep. She again notes K.S.'s plan to discontinue fentanyl and minimize Klonopin intake. She notes that bowel movements are normal. Respondent's plan is for diet and lifestyle change, staying on a soft diet, continuing the tapering of drugs, and consulting a chiropractor or physical therapist for pain. Respondent did not refer K.S. to any other physician.

14. K.S. consulted respondent on January 21, 2009. Respondent's notes indicate that K.S. has reduced the fentanyl patch and that she complains that her whole body aches and she is tired, has constant diarrhea, feels weak, and is dehydrated. Respondent notes drug withdrawal and that the patient seems to be going through personality/behavioral changes. Respondent recommended an herb preparation. Respondent did not refer K.S. to any other physician.

15. On January 25, 2009, K.S. left a voicemail message for respondent reporting her continuing physical distress, and respondent recommended that she see another physician for her physical symptoms. On January 26, 2009, K.S. went to the emergency room at John Muir Hospital and was given IV electrolytes and Zofran with a prescription for Imodium. The emergency room records show that K.S. stated that her symptoms were due to a recent onset of diarrhea, nausea, and vomiting secondary to eating a spinach salad two days earlier.

16. K.S. did not return to her treatment with respondent and sought out an addiction specialist for her drug withdrawal. In February 2009, she was being weaned off of fentanyl and Klonopin with a plan for maintenance treatment with suboxone.

17. K.S.'s complaint to the Board was triggered by a financial dispute. K.S. wanted to use the deposit her mother had at the clinic to pay at least part of K.S.'s bill. Respondent required a written authorization from K.S.'s mother. The one that K.S. supplied was questioned by the staff as a forgery. This made K.S. very angry and was clearly the impetus for the complaint to the board.

18. The Board's expert, Monica J. Stokes, M.D., states in her C.V. that she is in private practice in integrative medicine, and is a women's health consultant and author. It was established that she has experience treating patients using Ayurvedic medicine. Her expert testimony concerning respondent's failure to integrate the Ayurvedic medical modalities with western medical modalities in her treatment of K.S. was persuasive.

19. It was established by clear and convincing evidence through a qualified expert that it was an extreme departure from the standard of practice that respondent failed to consult with K.S.'s other treating practitioners to integrate her alternative treatments with knowledge of concurrent therapies, diagnosis, and assessments by other professionals and coordination of treatment in light of that knowledge.

20. When respondent noted possible mental health diagnoses for K.S., such as bipolar disorder, sleep disorder, anxiety and depression, she documented no basis for these diagnoses, and failed to refer K.S. for mental health treatment, confer with the patient's other treating physicians, or speak to K.S. about her concerns.

21. Respondent provided no detailed informed consent to K.S, written or documented to show that K.S. fully understood Ayurvedic approaches to treatment. K.S. did not provide informed consent that respondent's treatment was not intended to treat her physical symptoms or her detoxification process.

22. It was not established by clear and convincing evidence through an expert witness that respondent's training in Ayurvedic Medicine was inadequate or that her use of Ayurvedic therapies that she employed with K.S. were inappropriate.

23. Respondent's expert, Dean Nickles, M.D., found that although respondent's record keeping was below the standard of practice, her treatment of K.S. was within acceptable standards for wellness care. Dr. Nickles practices in Oakland. He opined that it was acceptable to take K.S. as a patient to ease the impact of drug withdrawal. However, he found respondent's records to be below the standard of practice. He accepted respondent's claim that she took vital signs after the initial visit. However, he agreed that if she did not take vital signs, it would be an extreme departure from the standard of practice given the complaints of K.S. There was no evidence that respondent actually took vital signs.

Inaccurate/Inadequate Recordkeeping – Patient K.S.

24. Respondent stipulated that her record keeping was inadequate. Her notations were sketchy and often illegible. Her progress notes contain very little information besides the patient's complaints. No vital signs are recorded, except on the initial visit. No assessment is noted. No treatment plan is noted. Respondent provides no detailed description of the modalities employed, the application to the patient, or the basis for the treatment. No components of herbal preparation, or, if prepackaged, the manufacturer, dosage, duration or indication are in the record. Respondent's records provide very little information concerning the connection between each modality employed, the advice given, the individual condition of the patient, and the outcome sought. Respondent documents no detailed informed consent or that K.S. was given any information concerning conventional treatment or alternatives. It was established by clear and convincing evidence through a qualified expert that respondent's record keeping taken as a whole (especially the lack of vital signs) was an extreme departure from the standard of practice.

Gross Negligence/Negligence/Incompetence – Patient J.F.

25. Patient J.F. first consulted respondent in February 2003, when he and his wife, S.F., were seeking a new primary care physician (PCP), or M.D. internist to act in that capacity, as their previous physician had retired. Respondent was initially consulted by J.F. for an upper respiratory tract infection. In March 2003, respondent referred J.F. to Alta Bates ER for a foot fracture, but did not see him in her office.

26. J.F. next saw respondent on October 21, 2005, at which time he complained of knee pan, hip pain due to osteoarthritis of the left hip, as well as anxiety and stress. He had declined a hip replacement at that time. J.F. also complained of groin pain, which respondent attributed to his hip disease. Respondent ordered supplements, recommended stress management measures (meditation), and ordered x-rays of the hip and knee. The xrays were followed by MRI's received in November 2001, which confirmed degenerative changes and other problems.

27. J.F.'s next visit with respondent was on November 1, 2005, at which time he complained of worsening left hip and knee pain and a stressful family situation. Respondent diagnosed hip and knee pain, stress and anxiety, insomnia, and fatigue. Among other things, respondent ordered a complete blood count (CBC) and comprehensive metabolic panel (CMP), as well as PSA alkaline phosphatase and homocysteine levels.

28. On November 3, 2005, J.F. consulted respondent for a "stress evaluation," and respondent noted that J.F. suffered from chronic pain and insomnia. Respondent noted that no genital or prostate examination was done. Respondent made recommendations. J.F. was seen on November 8, and 11 for hip pain treatments, and on November 11, 2005, respondent entered a diagnosis of hip and knee degenerative joint disease with pain, and she recommended treatments. On November 15, 2005, further knee and hip pain treatments were noted.

29. On November 12, 2005, blood tests were done by the laboratory and reported on November 17, 2005. The results indicated a mildly elevated prostate specific antigen level and a normal alkaline phosphatase level, as well as elevated cholesterol and homocysteine levels. Respondent noted the abnormal labs in the chart when she saw the patient on November 17, 2005, but there is no indication that she discussed the abnormal laboratory findings with J.F., performed a prostate examination or referred J.F. for a prostate examination. No follow-up plan was noted.

30. Respondent's claim that she discussed the laboratory results with J.F. and suggested a repeat PSA test and referred him to a urologist is not supported in the documentation. J.F. did not follow upon the elevated PSA. J.F.'s final visit with respondent in 2005 was on December 8, 2005. There is no mention in the chart that the elevated PSA test was discussed.

31. In March 2006, J.F. saw respondent after he was in a motor vehicle accident and sustained a back injury. He had several chiropractic treatments for the injury before consulting respondent. J.F. complained mostly about the continuing and worsening of his left hip and knee pain, which was exacerbated by the accident. Respondent recommended massage and acupuncture, and QiGong. Respondent received reports from her referrals. The report of the QiGong expert indicated the patient was complaining of groin pain.

32. By the next visit on May 1, 2006, J.F. reported that he was almost back to normal. Respondent concluded that no more treatments were needed. During June and July 2006, J.F. continued acupuncture treatments and respondent received reports from the acupuncturist.

33. J.F.'s next visit was on July 25, 2006 and it was a follow-up. J.F. reported getting better and respondent recommended continued treatments.

34. The last visit in 2006 was on August 28, 2006, when J.F. complained of eye pain after a trauma. Respondent referred him to an ophthalmologist. Respondent also referred J.F. to an ENT practice for evaluation of a six-month long hearing loss. Respondent received a report that J.F. had a mild hearing loss and recommended a further neurodiagnostic study. There is no notation in the record if this recommendation was followed.

35. J.F. next consulted respondent in February 2007, when he complained of chest wall pain as well as knee and hip pain. Respondent noted his back and right rib/chest pain and attributed it to chondrocondritis with no etiology noted. She recommended work with "Adam." A notation in the margin for this visit indicated "referred to MME Rx-Tucson." At her physician conference with the Board, respondent denied that she had referred J.F., but

that this was a magnetic treatment for which J.F. had requested a referral to help his joint pain.

36. J.F. had acupuncture and massage for his back, hip, and knee pain on February 26, and March 1, 2007, and the acupuncturist noted left hip and knee pain and also right rib chest pain.

37. J.F. and his wife visited family in Connecticut in May 2007. On May 16, 2007, he consulted a chiropractor there for back pain, The chiropractor did manipulative therapy, and ordered an abdominal ultrasound and lab work that included a PSA level. Lab results indicated a significant elevation in PSA to 182.1 ng/dl, which is way above normal, as well as elevated triglycerides, cholesterol, and an alkaline phosphatase level of 229 U/L which is high and up from his 2005 level. The laboratory sent a copy of the laboratory results to respondent's clinic. The chiropractor recommended to J.F. that he see a urologist for evaluation immediately upon return to California. J.F. consulted a urologist in Connecticut, who did a digital rectal examination and found suspicious hardening and nodules on the prostate, and recommended a biopsy.

38. J.F. left a message for respondent concerning his high PSA level and his fears of prostate cancer. J.F and his wife immediately began a search for a formal urological consultation, and made an appointment for evaluation and biopsy at the University of California San Francisco Medical Center (UCSF) five days before J.F.'s June 1, 2007 appointment with respondent. At the June 1, 2007, appointment, J.F. shared the lab results obtained in Connecticut. Respondent noted "awaiting biopsy." She also noted stress and anxiety, abdominal pain and hip DJD. Respondent recommended stress reduction, a CT scan, and biopsy. No laboratory orders are in the chart, and no referrals are noted. There is a copy in the chart of radiology results dated May 27, 2007 ordered by another medical professional. These results indicated a pleural based soft tissue mass along the right lateral mid-chest and recommended a CT scan of the chest.

39. According to respondent's medical records for J.F., at an appointment on June 4, 2007, the patient completed another stress evaluation and noted that he had urinary or growth problems. Respondent noted chest wall pain; abnormal labs, and left hip pain. She recommended Tylenol and additional neuromuscular rehabilitation treatments. The patient's last appointment was around June 1, 2007. Follow-up PSA and alkaline phosphatase levels, ordered by respondent were taken on June 26, 2007 and indicated a further elevation of PSA and alkaline phosphatase. A biopsy taken at UCSF on July 5, 2007, indicated Stage IV prostatic adenocarcinoma.

40. It was established by clear and convincing evidence through the testimony of a qualified expert, Dushyant N. Patel, M.D., that respondent's conduct constitutes gross negligence, repeated negligent acts and incompetence in that as a primary care physician and/or treating physician ordering and receiving laboratory results indicating an abnormal PSA level in November 2005, respondent failed to follow up on the result by explaining and discussing it and other abnormal results with the patient, ordering a repeat test, referring J.F. to a specialist, or doing a digital rectal examination herself. As soon as any physician orders routine laboratory work or screening studies for a patient, she is professionally obligated for the interpretation, evaluation, counseling and follow up care or she must refer the patient to

another physician for appropriate evaluation. She must follow up to check that the patient is following her recommendations. Respondent's treatment of J.F. focused on stress, sleep, and knee/hip pain and her laboratory testing was non-specific, consisting of tests such as biofeedback and dark field microscopy, none of which could provide findings indicating the presence of a major medical illness such as prostate cancer, or provide follow up information on the elevated PSA level.

41. Respondent never followed up on the initial elevated PSA level for her patient, even after he reported groin pain in October 2005, prior to the initial PSA test in November 2005, and groin pain again in April 2006, and groin and chest pain in early 2007. She attributed these symptoms to hip problems and condrochondritis. Groin pain and chest pain can be symptoms of prostate cancer and metastatic disease. Respondent was either ignorant of, or lacked the knowledge or ability to appreciate the importance of follow up on the initial elevated PSA finding for J.F. Respondent missed a number of opportunities to follow up with the elevated PSA. Even after the second PSA level was obtained in Connecticut, she did not document a referral to a urologist, and she did not order a biopsy or any other tests until June 25, 2007.

42. Respondent used both alternative medical therapies and an allopathic medical approach to the patient's care. J.F. was clearly committed to alternative medicine. However, respondent failed to follow up on what needed to be done to diagnose and treat J.F. There was no coherent treatment plan for J.F.

43. The Board's expert, Dushyant N. Patel, M.D., testified concerning the standard of practice for treating a patient with a 5.1 elevated PSA, who is over 50 years old. This situation requires a digital rectal examination to check the prostate. Then the standard of care requires a follow-up PSA. Respondent failed to follow up on J.F.'s complaints of groin pain, and rib pain. Respondent's conduct constitutes an extreme departure from the standard of care because she did not have a treatment plan for the elevated PSA. Vital signs are missing in many of the medical record notes. Respondent's failure to meet the standard of practice led to a delay in J.F. getting the diagnosis and treatment he needed. Respondent's expert, Dean J. Nickles, MD., stated that respondent's record keeping at the time did not include a problem list in the patient chart which would have served as an immediate reminder of any and all future and necessary procedures and tests to be performed for the patient. Dr. Nickles believes this failure created that lack of follow up.

Inaccurate/Inadequate Recordkeeping – Patient J.F..

44. Respondent claims she was not J.F.'s primary care physician (PCP), but she has no documented verbal or written agreement that made it clear that she did not intend to be his PCP. Even if she did not consider herself his PCP, she apparently did not document an inquiry as to whether he was seeing another physician as PCP, and she never indicated in his records any inquiry as to whether J.F. had followed up with any practitioner concerning the abnormal PSA result of November 2005, and she did not indicate a referral to a urologist or other specialist for follow up. Respondent admits that her record keeping is below the standard of practice and resulted in lack of follow up in this case. Respondent did not adequately or accurately document her care of J.F. The notations concerning J.F. are lacking

in detail and substance. For instance, in May 2006, J.F. received intravenous infusions and there is no clear chart notes that document what was given, the volume infused, over what time frame, how the patient tolerated the procedure or the patient's response to the treatment. Respondent does not identify the practitioner who administered the treatment. Except for an adequate general examination at J.F.'s initial visits in 2003 and 2005, respondent has no consistent record of physical examination findings or vital signs taken and recorded. The records are usually sketchy and often illegible.

Dishonesty

45. With respect to respondent's treatment of J.F., in a deposition taken under oath on February 12, 2009, in a civil case filed against respondent, she indicated that she never discussed prostate health with J.F. because, in her mind, she was not his primary care physician. She indicated that a PSA of 5.1 had to be followed up but not on an emergency basis. However, she did not do any follow up on J.F.'s elevated PSA and did not recall any discussion with J.F. concerning his PSA elevation. She further indicated that she would have sent J.F. to a urologist for follow up if she would have thought of it. As it was, she indicated, the elevated PSA obviously did not get followed up until "things got where they went."

46. On October 13, 2009, when respondent's deposition in the civil case was completed, respondent indicated that she may have discussed urinary function and PSA level with J.F. on November 17, 2005. She did not recall that on any subsequent visit she discussed urinary function or PSA levels. But it was usual for her to discuss these things with her patients, and she may just not have written it down. She had no specific recollections of discussing the 5.1 PSA, or recommending any follow up, but she must have told him to keep an eye on it and to follow up with her on it. She did not follow up between November 2005 and June 2007. She did not refer J.F. to a urologist. She never did a digital rectal examination. In fact, she testified that she does not do them. On February 27, 2007, when J.F. presented with chest wall pain, there was no discussion of abnormal labs or PSA. At the June 1, 2007 visit, respondent recalls J.F. had been seen at UCSF and the he was told to go for a biopsy by an urologist there.

47. On September 15, 2011, respondent had a physician conference with the Board with a medical consultant and a Board investigator. Respondent was represented by counsel at the conference. At that conference, respondent stated that she had detailed discussions with J.F. on November 17, 2005, concerning his abnormal labs, including the PSA results. She pointed out his borderline high PSA and explained his risk factors and the possible reasons for the result, that it could be anything from hypertrophy to cancer or maybe a lab error. She indicated that in one or two months, the PSA level needed to be checked again. She also advised J.F. to go to his "other doctors" for a digital rectal examination, but that she usually referred patients to a urologist. However, J.F. ignored her advice, as he usually ignored anything medical, preferring alternative healers. She did not do any urological examination at the November 17, 2005 visit or check the prostate, as he did not have any urinary symptoms. She reminded J.F. to have the PSA redone and to see a urologist whenever she saw him after that, not just during an appointment. She said J.F. told her he would take care of it but never did. She told J.F. to get the name of a urologist to whom she referred men at the front desk and make an appointment with him, and he was given a lab

slip for a repeat PSA test, but whenever she would check with him, he had not gone to the urologist or gotten the PSA done. Neither the lab slip nor an indication of referral to a urologist is in the patient's medical record. Respondent says that after the high PSA/alkaline prostate readings in Connecticut in mid 2007, J.F. went to a urologist and the urologist recommended a biopsy, but he refused to go, and at the June 1, 2007 appointment, she had to convince him to go for the biopsy. She stated that of the nine or 10 office visits that J.F. had between November 2005 and June 2007, she discussed his prostate and PSA with him a minimum of three or four times. She stated that the 5.1 PSA was borderline, a screening thing, and not an emergency, so she did not want to make it a "big deal."

48. The claimant contends that respondent exhibited dishonesty substantially related to the practice of medicine when she testified inconsistently at her deposition and at her November 2005 physician conference. While there are inconsistencies, these do not rise to the level of dishonesty. Memories can differ and change. Recall can change. What is clear is that respondent's records were not adequate or complete and therefore not helpful in reconstructing what actually was said and done.

49. On April 5, 2013, respondent submitted to the Office of Administrative Hearings a signed declaration under penalty of perjury that she had retained Monica Stokes, M.D. to be her expert on the K.S. case in April 2010 and that she had discussed K.S.'s treatment with her and had discussed her defenses to that case. This was at a time when there was no case pending against respondent concerning her treatment of K.S., but there was an investigation pending and the physician conference with the Board had just taken place. Dr. Stokes was retained to evaluate the K.S. case by the Board more than four months later. Dr. Stokes admits that she spoke to respondent in April 2010, about consulting with her on her integrative medical practices, but denies discussing any specific case or specific Board investigation. Respondent and her counsel requested that Dr. Stokes be disqualified as an expert for the Board. While Dr. Stokes' discussions give rise to a potential conflict of interest, she was allowed to testify. Although it appears that Dr. Stokes provided an unbiased written opinion, including some findings that were favorable to respondent, she exhibited bias when she testified, changing part of her opinion because she felt her integrity was attacked by the request to have her testimony excluded. While the better practice would have been for Dr. Stokes to recuse herself or for the Board to use a different expert, the use of Dr. Stokes was acceptable.

50. It was not established by clear and convincing evidence that respondent made false or misleading statements or that the statements she made constitute acts of dishonesty substantially related to the practice of medicine.

Other Matters

51. Respondent attended medical school and did her internship in India. After she came to the United States in about 1993, she did an internal medicine residency in Pennsylvania. She presently has a practice in Walnut Creek, California. She lists herself as "Internist/Geriatrician, Holistic Practitioner. She admits her record keeping was below the standard of practice. She attended the Medical Record Keeping Course given by the

University of California, San Diego School of Medicine Continuing Education Program from April 25 -26, 2013.

52. Taking into consideration all the evidence in this matter, this is not simply a case of poor record keeping, as respondent asserts. While it would not be against the public interest to allow respondent to continue to practice medicine, respondent will have the obligation to address the significant shortcomings in her practice, increase her medical knowledge, and improve her understanding of her duties as a physician and surgeon. The specific terms and conditions of probation are designed to protect the public and rehabilitate the respondent and are set forth in the Order below.

LEGAL CONCLUSIONS

1. By reason of the matters set forth in Findings 3 through 23, cause for disciplinary action exists in the case of K.S. pursuant to Business and Professions Code sections 2234, subdivision (b) (gross negligence), (c) repeated acts of negligence), and (d) (incompetence).

2. By reason of the matters set forth in Finding 24, cause for disciplinary action exists in the case of K.S. pursuant to Business and Professions Code section 2266 (failure to maintain adequate and accurate records.)

3. By reason of the matters set forth in Findings 25 through 43, cause for disciplinary action exists in the case of J.F. pursuant to Business and Professions Code sections 2234, subdivision (b) (gross negligence), (c) repeated acts of negligence), and (d) (incompetence).

4. By reason of the matters set forth in Finding 44, cause for disciplinary action exists in the case of J.F. pursuant to Business and Professions Code section 2266 (failure to maintain adequate and accurate records).

5. By reason of the matters set forth in Findings 45 through 50, it was not established by clear and convincing evidence that cause for disciplinary action exists pursuant to Business and Professions Code section 2234, subdivision (e) (dishonesty).

6. The matters set forth in Findings 51 and 52, have been considered in making the following order. This is consistent with Business and Professions Code section 2229, subdivision (b), which requires that disciplinary action should be "calculated to aid in the rehabilitation of the licensee, . . ." as long at the public can be protected. The terms and conditions of probation are designed to insure that respondent is safe to practice in California.

ORDER

Physician and Surgeon's Certificate No. A 67699 issued to respondent Suprabha Jain, M.D., is revoked. However, revocation is stayed and respondent is placed on probation for 35 months upon the following terms and conditions:

1. Clinical Training Program

Within 60 calendar days of the effective date of this Decision, respondent shall enroll in a clinical training or educational program equivalent to the Physician Assessment and Clinical Education Program (PACE) offered at the University of California - San Diego School of Medicine ("Program"). Respondent shall successfully complete the Program not later than six (6) months after respondent's initial enrollment unless the Board or its designee agrees in writing to an extension of that time.

The Program shall consist of a Comprehensive Assessment program comprised of a two-day assessment of respondent's physical and mental health; basic clinical and communication skills common to all clinicians; and medical knowledge, skill and judgment pertaining to respondent's area of practice in which respondent was alleged to be deficient, and at minimum, a 40 hour program of clinical education in the area of practice in which respondent was alleged to be deficient and which takes into account data obtained from the assessment, Decision(s), Accusation(s), and any other information that the Board or its designee deems relevant. Respondent shall pay all expenses associated with the clinical training program.

Based on respondent's performance and test results in the assessment and clinical education, the Program will advise the Board or its designee of its recommendation(s) for the scope and length of any additional educational or clinical training, treatment for any medical condition, treatment for any psychological condition, or anything else affecting respondent's practice of medicine. Respondent shall comply with Program recommendations.

At the completion of any additional educational or clinical training, respondent shall submit to and pass an examination. Determination as to whether respondent successfully completed the examination or successfully completed the program is solely within the program's jurisdiction.

If respondent fails to enroll, participate in, or successfully complete the clinical training program within the designated time period, respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. The respondent shall not resume the practice of medicine until enrollment or participation in the outstanding portions of the clinical training program have been completed. If the respondent did not successfully complete the clinical training program, the respondent shall not resume the practice of medicine until a final decision has been rendered on the accusation and/or a petition to revoke probation. The cessation of practice shall not apply to the reduction of the probationary time period.

2. Education Course

Within 60 calendar days of the effective date of this Decision, and on an annual basis thereafter, respondent shall submit to the Board or its designee for its prior approval educational program(s) or course(s) which shall not be less than 40 hours per year, for each year of probation. The educational program(s) or course(s) shall be aimed at correcting any areas of deficient practice or knowledge and shall be Category I certified, limited to

classroom, conference, or seminar settings. The educational program(s) or course(s) shall be at respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure. Following the completion of each course, the Board or its designee may administer an examination to test respondent's knowledge of the course. Respondent shall provide proof of attendance for 65 hours of CME of which 40 hours were in satisfaction of this condition.

3. Medical Record Keeping Course

Within 60 calendar days of the effective date of this decision, respondent shall enroll in a course in medical record keeping, at respondent's expense, approved in advance by the Board or its designee. Failure to successfully complete the course during the first six months of probation is a violation of probation. Respondent's successful completion of the UC San Diego School of Medicine Medical Record Keeping Course completed on April 26, 2013, meets the requirements of this condition.

A medical record keeping course taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Board or its designee had the course been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the course, or not later than 15 calendar days after the effective date of the Decision, whichever is later.

4. Monitoring -Practice

Within 30 calendar days of the effective date of this Decision, respondent shall submit to the Board or its designee for prior approval as a practice monitor, the name and qualifications of one or more licensed physicians and surgeons whose licenses are valid and in good standing, and who are preferably American Board of Medical Specialties (ABMS) certified. A monitor shall have no prior or current business or personal relationship with respondent, or other relationship that could reasonably be expected to compromise the ability of the monitor to render fair and unbiased reports to the Board, including but not limited to any form of bartering, shall be in respondent's field of practice, and must agree to serve as respondent's monitor. Respondent shall pay all monitoring costs.

The Board or its designee shall provide the approved monitor with copies of the Decision(s) and Accusation(s), and a proposed monitoring plan. Within 15 calendar days of receipt of the Decision(s), Accusation(s), and proposed monitoring plan, the monitor shall submit a signed statement that the monitor has read the Decision(s) and Accusation(s), fully understands the role of a monitor, and agrees or disagrees with the proposed monitoring plan. If the monitor disagrees with the proposed monitoring plan, the monitor shall submit a revised monitoring plan with the signed statement for approval by the Board or its designee.

Within 60 calendar days of the effective date of this Decision, and continuing throughout probation, respondent's practice shall be monitored by the approved monitor.

Respondent shall make all records available for immediate inspection and copying on the premises by the monitor at all times during business hours and shall retain the records for the entire term of probation.

If respondent fails to obtain approval of a monitor within 60 calendar days of the effective date of this Decision, respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall cease the practice of medicine until a monitor is approved to provide monitoring responsibility.

The monitor shall submit a quarterly written report to the Board or its designee which includes an evaluation of respondent's performance, indicating whether respondent's practices are within the standards of practice of medicine, and whether respondent is practicing medicine safely.

It shall be the sole responsibility of respondent to ensure that the monitor submits the quarterly written reports to the Board or its designee within 10 calendar days after the end of the preceding quarter.

If the monitor resigns or is no longer available, respondent shall, within 5 calendar days of such resignation or unavailability, submit to the Board or its designee, for prior approval, the name and qualifications of a replacement monitor who will be assuming that responsibility within 15 calendar days. If respondent fails to obtain approval of a replacement monitor within 60 days of the resignation or unavailability of the monitor, respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall cease the practice of medicine until a replacement monitor is approved and assumes monitoring responsibility.

In lieu of a monitor, respondent may participate in a professional enhancement program equivalent to the one offered by the Physician Assessment and Clinical Education Program at the University of California, San Diego School of Medicine, that includes, at minimum, quarterly chart review, semi-annual practice assessment, and semi-annual review of professional growth and education. Respondent shall participate in the professional enhancement program at respondent's expense during the term of probation.

Failure to maintain all records, or to make all appropriate records available for immediate inspection and copying on the premises, or to comply with this condition as outlined above is a violation of probation.

5. Notification

Within seven (7) days of the effective date of this Decision, the respondent shall provide a true copy of this Decision and Accusation to the Chief of Staff or the Chief Executive Officer at every hospital where privileges or membership are extended to respondent, at any other facility where respondent engages in the practice of medicine, including all physician and locum tenens registries or other similar agencies, and to the Chief Executive Officer at every insurance carrier which extends malpractice insurance coverage to

respondent. Respondent shall submit proof of compliance to the Board or its designee within 15 calendar days.

This condition shall apply to any change(s) in hospitals, other facilities or insurance carrier.

6. Supervision of Physician Assistants

During probation, respondent is prohibited from supervising physician assistants.

7. Obey All Laws

Respondent shall obey all federal, state and local laws, all rules governing the practice of medicine in California and remain in full compliance with any court ordered criminal probation, payments, and other orders.

8. Quarterly Declarations

Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Board, stating whether there has been compliance with all the conditions of probation.

Respondent shall submit quarterly declarations not later than 10 calendar days after the end of the preceding quarter.

9. General Probation Requirements

a. Compliance with Probation Unit: Respondent shall comply with the Board's probation unit and all terms and conditions of this Decision.

b. Address Changes: Respondent shall, at all times, keep the Board informed of respondent's business and residence addresses, email address (if available), and telephone number. Changes of such addresses shall be immediately communicated in writing to the Board or its designee. Under no circumstances shall a post office box serve as an address of record, except as allowed by Business and Professions Code section 2021(b).

c. Place of Practice: Respondent shall not engage in the practice of medicine in respondent's or patient's place of residence, unless the patient resides in a skilled nursing facility or other similar licensed facility.

d. License Renewal: Respondent shall maintain a current and renewed California physician's and surgeon's license.

e. Travel or Residence Outside California: Respondent shall immediately inform the Board or its designee, in writing, of travel to any areas outside the jurisdiction of California which lasts, or is contemplated to last, more than thirty (30) calendar days. In the event respondent should leave the State of

California to reside or to practice respondent shall notify the Board or its designee in writing 30 calendar days prior to the dates of departure and return.

10. Interview with the Board or its Designee

Respondent shall be available in person upon request for interviews either at respondent's place of business or at the probation unit office, with or without prior notice throughout the term of probation.

11. Non-practice While on Probation

Respondent shall notify the Board or its designee in writing within 15 calendar days of any periods of non-practice lasting more than 30 calendar days and within 15 calendar days of respondent's return to practice. Non-practice is defined as any period of time respondent is not practicing medicine in California as defined in Business and Professions Code sections 2051 and 2052 for at least 40 hours in a calendar month in direct patient care, clinical activity or teaching, or other activity as approved by the Board. All time spent in an intensive training program which has been approved by the Board or its designee shall not be considered non-practice. Practicing medicine in another state of the United States or Federal jurisdiction while on probation with the medical licensing authority of that state or jurisdiction shall not be considered non-practice. A Board-ordered suspension of practice shall not be considered as a period of non-practice.

In the event respondent's period of non-practice while on probation exceeds 18 calendar months, respondent shall successfully complete a clinical training program that meets the criteria of Condition 18 of the current version of the Board's "Manual of Model Disciplinary Orders and Disciplinary Guidelines" prior to resuming the practice of medicine.

Respondent's period of non-practice while on probation shall not exceed two (2) years.

Periods of non-practice will not apply to the reduction of the probationary term.

Periods of non-practice will relieve respondent of the responsibility to comply with the probationary terms and conditions with the exception of this condition and the following terms and conditions of probation: Obey All Laws; and General Probation Requirements.

12. Completion of Probation

Respondent shall comply with all financial obligations (e.g., restitution, probation costs) not later than 120 calendar days prior to the completion of probation. Upon successful completion of probation, respondent's certificate shall be fully restored.

13. Violation of Probation

Failure to fully comply with any term or condition of probation is a violation of probation. If respondent violates probation in any respect, the Board, after giving respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary

order that was stayed. If an Accusation, or Petition to Revoke Probation, or an Interim Suspension Order is filed against respondent during probation, the Board shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

14. License Surrender

Following the effective date of this Decision, if respondent ceases practicing due to retirement or health reasons or is otherwise unable to satisfy the terms and conditions of probation, respondent may request to surrender his or her license. The Board reserves the right to evaluate respondent's request and to exercise its discretion in determining whether or not to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the surrender, respondent shall within 15 calendar days deliver respondent's wallet and wall certificate to the Board or its designee and respondent shall no longer practice medicine. Respondent will no longer be subject to the terms and conditions of probation. If respondent re-applies for a medical license, the application shall be treated as a petition for reinstatement of a revoked certificate.

15. Probation Monitoring Costs

Respondent shall pay the costs associated with probation monitoring each and every year of probation, as designated by the Board, which may be adjusted on an annual basis. Such costs shall be payable to the Medical Board of California and delivered to the Board or its designee no later than January 31 of each calendar year.

This decision shall become effective at 5 p.m. on March 28, 2014.

IT IS SO ORDERED this 27th day of February, 2014.

BARBARA YAROSLAVSKY, CHAIR
PANEL A
MEDICAL BOARD of CALIFORNIA

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:	Case No. 12-2009-197864
SUPRABHA JAIN, M.D.	OAH No. 2012070765
Physician's & Surgeon's Certificate No. A 67699	
Respondent.	

ORDER OF NON-ADOPTION OF PROPOSED DECISION

The Proposed Decision of the Administrative Law Judge in the above-entitled matter has been **non-adopted.** A panel of the Medical Board of California (Board) will decide the case upon the record, including the transcript and exhibits of the hearing, and upon such written argument as the parties may wish to submit, including any argument directed to the question of whether the proposed Order sufficiently protects the public. The parties will be notified of the date for submission of such argument when the transcript of the above-mentioned hearing becomes available.

To order a copy of the transcript, please contact Diamond Court Reporters, 1107 2nd Street, Suite 210, Sacramento, CA 95814. Their telephone number is (916) 498-9288.

To order a copy of the exhibits, please submit a written request to this Board.

In addition to written argument, oral argument will be scheduled if any party files with the Board within 20 days from the date of this notice a written request for oral argument. If a timely request is filed, the Board will serve all parties with written notice of the time, date and place for oral argument. Please do not attach to your written argument any documents that are not part of the record as they cannot be considered by the Panel. The Board directs the parties attention to Title 16 of the California Code of Regulations, sections 1364.30 and 1364.32 for additional requirements regarding the submission of oral and written argument.

Please remember to serve the opposing party with a copy of your written argument and any other papers you might file with the Board. The mailing address of the Board is as follows:

MEDICAL BOARD OF CALIFORNIA
2005 Evergreen Street, Suite 1200
Sacramento, CA 95815-3831
(916) 263-6668
Attention: Kelly Montalbano

Dated: November 14, 2013

Barbara Yaroslavsky, Panel A Chair

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: SUPRABHA JAIN, M.D., Physician and Surgeon's Certificate No. A 67699 Respondent.	Case No. 12-2009-197864 OAH No. 2012070765

PROPOSED DECISION

Administrative Law Judge Ruth S. Astle, State of California, Office of Administrative Hearings, heard this matter in Oakland, California on May 13, 14, 15, 16 and June 19 and 20, 2013.

Vivian Hara, Deputy Attorney General, represented complainant.

Respondent Suprabha Jain, M.D., was present and represented by Robert W. Hodges, Attorney at Law.

Submission of the matter was deferred for receipt of final arguments, which were received and considered. The matter was submitted on August 21, 2013.

FACTUAL FINDINGS

1. Complainant Kimberly Kirchmeyer made this accusation in her official capacity as the Interim Executive Director of the Medical Board of California (Board

2. On March 5, 1999, Physician and Surgeon's Certificate No. A 67699 was issued by the Board to Suprabha Jain, M.D. (respondent). Respondent's certificate will expire March 31, 2015, unless renewed.

Respondent has not been the subject of prior disciplinary action.

Gross Negligence/Negligence/Incompetence - Patient K.S.

3. K.S. first consulted respondent at Mt. Diablo Wellness Center, Inc. (MDI) on January 4, 2009. K.S. had issues with anxiety, depression, and pain since she was 28 years old. She had consulted an acupuncturist and a chiropractor. She was also a patient of an integrative pain management clinic in Concord, California. Respondent was never K.S.'s primary care physician. K.S. suffered from chronic neck and low back pain; her weight was 210 pounds at the time she first consulted respondent. She also complained of always being cold and sleeping 14 hours a day. She indicated on her MDI patient information sheet that her reason for consulting respondent was "sweats and muscle spasm."

4. K.S. reported that in the previous year, she had decided to reduce or eliminate a number of drugs she was taking for her medical conditions. Her prescribed drugs included Advair, albuterol, Xanax, Dilaudid, Oxycodone, Effexor, Abilify, Klonopin, fentanyl patches, and a stool softener. She had been reducing or eliminating the drugs by herself without medical supervision. She stopped using all prescribed medications except Klonopin and fentanyl patches at the time she consulted respondent.

5. When K.S. began suffering from sweats and nausea, her son recommended respondent's clinic. K.S.'s mother had been respondent's patient previously and had $5,000 in unapplied deposits reserved at MDI. K.S. called MDI and was able to make an appointment with respondent for the next day, January 4, 2009. K.S. filled out a patient information sheet and was examined by respondent. Respondent recognized that K.S. was suffering the effects of narcotics/controlled substance withdrawal.

6. Respondent developed a "medical model" form for intake history and physical. On January 4, 2009, K.S. filled out the first page of a patient information form; the second page was left blank. Respondent recorded a brief medical history of K.S. in her progress notes and recorded vital signs. After this initial intake form, there are no other vital signs recorded. Respondent had laboratory tests performed on K.S., including a complete blood count (CBC), urinalysis, chemistry panel, and toxicology screen. All laboratory values were within normal limits, and the toxicology screen was negative, even for benzodiazepines, such as Klonopin, or opiates such as fentanyl. Respondent did not repeat the laboratory tests.

7. On January 5, 2009, K.S. signed her payment agreement and had the program of treatment explained to her, which included live blood cell analysis, "full body" detoxification, Ayurvedic yoga therapy, healthy cooking, meditation, bioresonance sessions, and IV vitamins and chelation as needed. K.S. was provided with some material describing the purposes behind the therapies, general principles and guidelines of Ayurvedic therapies, a healthy cooking food menu, the Ayurvedic toxin-elimination regimen, and live blood evaluation pictorial worksheets. Respondent filled out a history and physical form which included information about the patient's current medications, which were fentanyl patch and Klonopin; and her current symptoms, which included excessive sweating, anxiety, severe neck pain, overweight, sleeplessness, and drug withdrawal. No vital signs were recorded on

the physical examination portion. This form included a nutritional intake evaluation, where the patient's usual diet was recorded.

8. Respondent described her mode of medical practice as primarily including a spiritual aspect, where the patient's mind, body, and spirit are involved. She developed a body constitution questionnaire for this aspect, where the patient assesses his or her general state of mind and body. K.S filled out this form on January 5, 2009. Respondent believes this aspect of treatment requires connecting and bonding with the patient and that there are no templates for documenting this type of work. On January 5, 2009, K.S. presented respondent with a schedule that the patient wanted to use for tapering off the Klonopin and fentanyl. On that same day, K.S. received a colon cleansing assessment in which a severely impacted bowel was found and colonic irrigation was scheduled. K.S. also received a therapeutic breathing treatment that day and again on January 7 and 9, 2009. Respondent discontinued the stool softener and prescribed Libidex cream and other herbal medications.

9. K.S. enrolled in respondent's wellness program and not in a pain management program or for assistance with drug withdrawal. Both K.S. and respondent were aware that K.S. was decreasing her drug regimen. Respondent saw her role as supporting the patient's withdraw, not directing it. Respondent did not consult with the patient's pain management physicians or obtain medical records from the patient's prescribers.

10. K.S. saw respondent on a daily basis during this time. Respondent disimpacted the patient's bowel and recommended more fiber and warm water intake in addition to herbal remedies.

11. K.S. continued a variety of treatments over a two-week period. K.S. was experiencing nausea, and weakness with fatigue. By January 14, 2009, respondent noted K.S. was tired and dehydrated, and she was given intravenous (IV) vitamin treatment. On January 16, 2009, K.S. reported extreme fatigue, insomnia, and diarrhea. Respondent again administered IV treatment with a vitamin and mineral solution.

12. On January 17, 2009, respondent made a house call because K.S. was too weak to go into the clinic. Respondent recommended fluids and supplements with a slowly advancing vegetable diet, as well as an over-the-counter anti-emetic. Respondent noted that K.S.'s drug dependence/withdrawal was still fluctuating, but with more "better" moments. Respondent documents a "long talk" with K.S. about her past traumas and emotional stressors.

13. Respondent saw K.S. at MDI on January 20, 2009. Respondent notes loss of weight, night sweats, and loss of sleep. She again notes K.S.'s plan to discontinue fentanyl and minimize Klonopin intake. She notes that bowel movements are normal. Respondent's plan is for diet and lifestyle change, staying on a soft diet, continuing the tapering of drugs, and consulting a chiropractor or physical therapist for pain. Respondent did not refer K.S. to any other physician.

14. K.S. consulted respondent on January 21, 2009. Respondent's notes indicate that K.S. has reduced the fentanyl patch and that she complains that her whole body aches and she is tired, has constant diarrhea, feels weak, and is dehydrated. Respondent notes drug withdrawal and that the patient seems to be going through personality/behavioral changes. Respondent recommended an herb preparation. Respondent did not refer K.S. to any other physician.

15. On January 25, 2009, K.S. left a voicemail message for respondent reporting her continuing physical distress, and respondent recommended that she see another physician for her physical symptoms. On January 26, 2009, K.S. went to the emergency room at John Muir Hospital and was given IV electrolytes and Zofran with a prescription for Imodium. The emergency room records show that K.S. stated that her symptoms were due to a recent onset of diarrhea, nausea, and vomiting secondary to eating a spinach salad two days earlier.

16. K.S. did not return to her treatment with respondent and sought out an addiction specialist for her drug withdrawal. In February 2009, she was being weaned off of fentanyl and Klonopin with a plan for maintenance treatment with suboxone.

17. It was established by clear and convincing evidence through a qualified expert that it was an extreme departure from the standard of practice that respondent failed to consult with K.S.'s other treating practitioners to integrate her alternative treatments with knowledge of concurrent therapies, diagnosis, and assessments by other professionals and coordination of treatment in light of that knowledge.

18. Respondent provided no detailed informed consent to K.S, written or documented to show that K.S. fully understood Ayurvedic approaches to treatment. K.S. did not provide informed consent that respondent's treatment was not intended to treat her physical symptoms or her detoxification process.

19. When respondent noted possible mental health diagnoses for K.S., such as bipolar disorder, sleep disorder, anxiety and depression, she documented no basis for these diagnoses, and failed to refer K.S. for mental health treatment, confer with the patient's other treating physicians, or speak to K.S. about her concerns.

20. It was not established by clear and convincing evidence through an expert witness that respondent's training in Ayurvedic Medicine was inadequate or that her use of Ayurvedic therapies that she employed with K.S. were inappropriate.

21. K.S.'s complaint to the board was triggered by a financial dispute. K.S. wanted to use the deposit her mother had at the clinic to pay at least part of K.S.'s bill. Respondent required a written authorization from K.S.'s mother. The one that K.S. supplied was questioned by the staff as a forgery. This made K.S. very angry and was clearly the impetus for the complaint to the board.

22. The Board's expert, Monica J. Stokes, M.D., states in her C.V. that she is in private practice in integrative medicine, and is a women's health consultant and author. It was not established that she ever treated any patients using Ayurvedic medicine. Her criticisms of respondent in that regard were not persuasive. However, her expert testimony concerning respondent's failure to integrate the Ayurvedic medical modalities with western medical modalities was persuasive.

23. Respondent's expert, Dean Nickles, M.D., found that although respondent's record keeping was below the standard of practice, her treatment of K.S. was within acceptable standards for wellness care. Dr. Nickles practices in Oakland. He opined that it was acceptable to take K.S. as a patient to ease the impact of drug withdrawal. However, he found respondent's records to be below the standard of practice. He accepted respondent's claim that she took vital signs after the initial visit. However, he agreed that if she did not take vital signs, it would be an extreme departure from the standard of practice given the complaints of K.S. There was no evidence that respondent actually took vital signs.

Inaccurate/Inadequate Recordkeeping – Patient K.S.

24. Respondent stipulated that her record keeping was inadequate. Her notations were sketchy and often illegible. Her progress notes contain very little information besides the patient's complaints. No vital signs are recorded, except on the initial visit. No assessment is noted. No treatment plan is noted. Respondent provides no detailed description of the modalities employed, the application to the patient, or the basis for the treatment. No components of herbal preparation, or, if prepackaged, the manufacturer, dosage, duration or indication are in the record. Respondent's records provide very little information concerning the connection between each modality employed, the advice given, the individual condition of the patient, and the outcome sought. Respondent documents no detailed informed consent or that K.S. was given any information concerning conventional treatment or alternatives. It was established by clear and convincing evidence through a qualified expert that respondent's record keeping taken as a whole (especially the lack of vital signs) was an extreme departure from the standard of practice.

Gross Negligence/Negligence/Incompetence – Patient J.F.

25. Patient J.F. first consulted respondent in February 2003, when he and his wife, S.F., were seeking a new primary care physician (PCP), or M.D. internist to act in that capacity, as their previous physician had retired. Respondent was initially consulted by J.F. for an upper respiratory tract infection. In March 2003, respondent referred J.F. to Alta Bates ER for a foot fracture, but did not see him in her office.

26. J.F. next saw respondent on October 21, 2005, at which time he complained of knee pan, hip pain due to osteoarthritis of the left hip, as well as anxiety and stress. He had declined a hip replacement at that time. J.F. also complained of groin pain, which respondent attributed to his hip disease. Respondent ordered supplements, recommended stress management measures (meditation), and ordered x-rays of the hip and knee. The x-

rays were followed by MRI's received in November 2001, which confirmed degenerative changes and other problems.

27. J.F.'s next visit with respondent was on November 1, 2005, at which time he complained of worsening left hip and knee pain and a stressful family situation. Respondent diagnosed hip and knee pain, stress and anxiety, insomnia, and fatigue. Among other things, respondent ordered a complete blood count (CBC) and comprehensive metabolic panel (CMP), as well as PSA alkaline phosphatase and homocysteine levels.

28. On November 3, 2005, J.F. consulted respondent for a "stress evaluation," and respondent noted that J.F. suffered from chronic pain and insomnia. Respondent noted that no genital or prostate examination was done. Respondent made recommendations. J.F. was seen on November 8, and 11 for hip pain treatments, and on November 11, 2005, respondent entered a diagnosis of hip and knee degenerative joint disease with pain, and she recommended treatments. On November 15, 2005, further knee and hip pain treatments were noted.

29. On November 12, 2005, blood tests were done by the laboratory and reported on November 17, 2005. The results indicated a mildly elevated prostate specific antigen level and a normal alkaline phosphatase level, as well as elevated cholesterol and homocysteine levels. Respondent noted the abnormal labs in the chart when she saw the patient on November 17, 2005, but there is no indication that she discussed the abnormal laboratory findings with J.F., performed a prostate examination or referred J.F. for a prostate examination. No follow-up plan was noted.

30. Respondent's claim that she discussed the laboratory results with J.F. and suggested a repeat PSA test and referred him to a urologist is not supported in the documentation. J.F. did not follow upon the elevated PSA. J.F.'s final visit with respondent in 2005 was on December 8, 2005. There is no mention in the chart that the elevated PSA test was discussed.

31. In March 2006, J.F. saw respondent after he was in a motor vehicle accident and sustained a back injury. He had several chiropractic treatments for the injury before consulting respondent. J.F. complained mostly about the continuing and worsening of his left hip and knee pain, which was exacerbated by the accident. Respondent recommended massage and acupuncture, and QiGong. Respondent received reports from her referrals. The report of the QiGong expert indicated the patient was complaining of groin pain.

32. By the next visit on May 1, 2006, J.F. reported that he was almost back to normal. Respondent concluded that no more treatments were needed. During June and July 2006, J.F. continued acupuncture treatments and respondent received reports from the acupuncturist.

33. J.F.'s next visit was on July 25, 2006 and it was a follow-up. J.F. reported getting better and respondent recommended continued treatments.

35. The last visit in 2006 was on August 28, 2006, when J.F. complained of eye pain after a trauma. Respondent referred him to an ophthalmologist. Respondent also referred J.F. to an ENT practice for evaluation of a six-month long hearing loss. Respondent received a report that J.F. had a mild hearing loss and recommended a further neurodiagnostic study. There is no notation in the record if this recommendation was followed.

36. J.F. next consulted respondent in February 2007, when he complained of chest wall pain as well as knee and hip pain. Respondent noted his back and right rib/chest pain and attributed it to chondrocondritis with no etiology noted. She recommended work with "Adam." A notation in the margin for this visit indicated "referred to MME Rx-Tucson." At her physician conference with the Board, respondent denied that she had referred J.F., but that this was a magnetic treatment for which J.F. had requested a referral to help his joint pain.

37. J.F. had acupuncture and massage for his back, hip, and knee pain on February 26, and March 1, 2007, and the acupuncturist noted left hip and knee pain and also right rib chest pain.

38. J.F. and his wife visited family in Connecticut in May 2007. On May 16, 2007, he consulted a chiropractor there for back pain, The chiropractor did manipulative therapy, and ordered an abdominal ultrasound and lab work that included a PSA level. Lab results indicated a significant elevation in PSA to 182.1 ng/dl, which is way above normal, as well as elevated triglycerides, cholesterol, and an alkaline phosphatase level of 229 U/L which is high and up from his 2005 level. The laboratory sent a copy of the laboratory results to respondent's clinic. The chiropractor recommended to J.F. that he see a urologist for evaluation immediately upon return to California. J.F. consulted a urologist in Connecticut, who did a digital rectal examination and found suspicious hardening and nodules on the prostate, and recommended a biopsy.

39. J.F. left a message for respondent concerning his high PSA level and his fears of prostate cancer. J.F and his wife immediately began a search for a formal urological consultation, and made an appointment for evaluation and biopsy at the University of California San Francisco Medical Center (UCSF) five days before J.F.'s June 1, 2007 appointment with respondent. At the June 1, 2007, appointment, J.F. shared the lab results obtained in Connecticut. Respondent noted "awaiting biopsy." She also noted stress and anxiety, abdominal pain and hip DJD. Respondent recommended stress reduction, a CT scan, and biopsy. No laboratory orders are in the chart, and no referrals are noted. There is a copy in the chart of radiology results dated May 27, 2007 ordered by another medical professional. These results indicated a pleural based soft tissue mass along the right lateral mid-chest and recommended a CT scan of the chest.

40. According to respondent's medical records for J.F., at an appointment on June 4, 2007, the patient completed another stress evaluation and noted that he had urinary or

growth problems. Respondent noted chest wall pain; abnormal labs, and left hip pain. She recommended Tylenol and additional neuromuscular rehabilitation treatments. The patient's last appointment was around June 1, 2007. Follow-up PSA and alkaline phosphatase levels, ordered by respondent were taken on June 26, 2007 and indicated a further elevation of PSA and alkaline phosphatase. A biopsy taken at UCSF on July 5, 2007, indicated Stage IV prostatic adenocarcinoma.

41. It was established by clear and convincing evidence through the testimony of a qualified expert, Dushyant N. Patel, M.D., that respondent's conduct constitutes gross negligence, repeated negligent acts and incompetence in that as a primary care physician and/or treating physician ordering and receiving laboratory results indicating an abnormal PSA level in November 2005, respondent failed to follow up on the result by explaining and discussing it and other abnormal results with the patient, ordering a repeat test, referring J.F. to a specialist, or doing a digital rectal examination herself. As soon as any physician orders routine laboratory work or screening studies for a patient, she is professionally obligated for the interpretation, evaluation, counseling and follow up care or she must refer the patient to another physician for appropriate evaluation. She must follow up to check that the patient is following her recommendations. Respondent's treatment of J.F. focused on stress, sleep, and knee/hip pain and her laboratory testing was non-specific, consisting of tests such as biofeedback and dark field microscopy, none of which could provide findings indicating the presence of a major medical illness such as prostate cancer, or provide follow up information on the elevated PSA level.

42. Respondent never followed up on the initial elevated PSA level for her patient, even after he reported groin pain in October 2005, prior to the initial PSA test in November 2005, and groin pain again in April 2006, and groin and chest pain in early 2007. She attributed these symptoms to hip problems and condrochondritis. Groin pain and chest pain can be symptoms of prostate cancer and metastatic disease. Respondent was either ignorant of, or lacked the knowledge or ability to appreciate the importance of follow up on the initial elevated PSA finding for J.F. Respondent missed a number of opportunities to follow up with the elevated PSA. Even after the second PSA level was obtained in Connecticut, she did not document a referral to a urologist, and she did not order a biopsy or any other tests until June 25, 2007.

43. Respondent used both alternative medical therapies and an allopathic medical approach to the patient's care. J.F. was clearly committed to alternative medicine. However, respondent failed to follow up on what needed to be done to diagnose and treat J.F. There was no coherent treatment plan for J.F.

44. The Board's expert, Dushyant N. Patel, M.D., testified concerning the standard of practice for treating a patient with a 5.1 elevated PSA, who is over 50 years old. This situation requires a digital rectal examination to check the prostate. Then the standard of care requires a follow-up PSA. Respondent failed to follow up on J.F.'s complaints of groin pain, and rib pain. Respondent's conduct constitutes an extreme departure from the standard of care because she did not have a treatment plan for the elevated PSA. Vital signs are

missing in many of the medical record notes. Respondent's failure to meet the standard of practice led to a delay in J.F. getting the diagnosis and treatment he needed. Respondent's expert, Dean J. Nickles, MD., stated that respondent's record keeping at the time did not include a problem list in the patient chart which would have served as an immediate reminder of any and all future and necessary procedures and tests to be performed for the patient. Dr. Nickles believes this failure created that lack of follow up.

Inaccurate/Inadequate Recordkeeping – Patient J.F..

45. Respondent claims she was not J.F.'s primary care physician (PCP), but she has no documented verbal or written agreement that made it clear that she did not intend to be his PCP. Even if she did not consider herself his PCP, she apparently did not document an inquiry as to whether he was seeing another physician as PCP, and she never indicated in his records any inquiry as to whether J.F. had followed up with any practitioner concerning the abnormal PSA result of November 2005, and she did not indicate a referral to a urologist or other specialist for follow up. Respondent admits that her record keeping is below the standard of practice and resulted in lack of follow up in this case. Respondent did not adequately or accurately document her care of J.F. The notations concerning J.F. are lacking in detail and substance. For instance, in May 2006, J.F. received intravenous infusions and there is no clear chart notes that document what was given, the volume infused, over what time frame, how the patient tolerated the procedure or the patient's response to the treatment. Respondent does no identify the practitioner who administered the treatment. Except for an adequate general examination at J.F.'s initial visits in 2003 and 2005, respondent has not consistent record of physical examination findings or vital signs taken and recorded. The records are usually sketchy and often illegible.

Dishonesty

46. With respect to respondent's treatment of J.F., in a deposition taken under oath on February 12, 2009, in a civil case filed against respondent, she indicated that she never discussed prostate health with J.F. because, in her mind, she was not his primary care physician. She indicated that a PSA of 5.1 had to be followed up but not on an emergency basis. However, she did not do any follow up on J.F.'s elevated PSA and did not recall any discussion with J.F. concerning his PSA elevation. She further indicated that she would have sent J.F. to a urologist for follow up if she would have thought of it. As it was, she indicated, the elevated PSA obviously did not get followed up until "things got where they went."

47. On October 13, 2009, when respondent's deposition in the civil case was completed, respondent indicated that she may have discussed urinary function and PSA level with J.F. on November 17, 2005. She did not recall that on any subsequent visit she discussed urinary function or PSA levels. But it was usual for her to discuss these things with her patients, and she may just not have written it down. She had no specific recollections of discussing the 5.1 PSA, or recommending any follow up, but she must have told him to keep an eye on it and to follow up with her on it. She did not follow up between November 2005 and June 2007. She did not refer J.F. to a urologist. She never did a digital

rectal examination. In fact, she testified that she does not do them. On February 27, 2007, when J.F. presented with chest wall pain, there was no discussion of abnormal labs or PSA. At the June 1, 2007 visit, respondent recalls J.F. had been seen at UCSF and the he was told to go for a biopsy by an urologist there.

48. On September 15, 2011, respondent had a physician conference with the Board with a medical consultant and a Board investigator. Respondent was represented by counsel at the conference. At that conference, respondent stated that she had detailed discussions with J.F. on November 17, 2005, concerning his abnormal labs, including the PSA results. She pointed out his borderline high PSA and explained his risk factors and the possible reasons for the result, that it could be anything from hypertrophy to cancer or maybe a lab error. She indicated that in one or two months, the PSA level needed to be checked again. She also advised J.F. to go to his "other doctors" for a digital rectal examination, but that she usually referred patients to a urologist. However, J.F. ignored her advice, as he usually ignored anything medical, preferring alternative healers. She did not do any urological examination at the November 17, 2005 visit or check the prostate, as he did not have any urinary symptoms. She reminded J.F. to have the PSA redone and to see a urologist whenever she saw him after that, not just during an appointment. She said J.F. told her he would take care of it but never did. She told J.F. to get the name of a urologist to whom she referred men at the front desk and make an appointment with him, and he was given a lab slip for a repeat PSA test, but whenever she would check with him, he had not gone to the urologist or gotten the PSA done. Neither the lab slip nor an indication of referral to a urologist is in the patient's medical record. Respondent says that after the high PSA/alkaline prostate readings in Connecticut in mid 2007, J.F. went to a urologist and the urologist recommended a biopsy, but he refused to go, and at the June 1, 2007 appointment, she had to convince him to go for the biopsy. She stated that of the nine or 10 office visits that J.F. had between November 2005 and June 2007, she discussed his prostate and PSA with him a minimum of three or four times. She stated that the 5.1 PSA was borderline, a screening thing, and not an emergency, so she did not want to make it a "big deal."

49. The Board contends that respondent exhibited dishonesty substantially related to the practice of medicine when she testified inconsistently at her deposition and at her November 2005 physician conference. While there are inconsistencies, these do not rise to the level of dishonesty. Memories can differ and change. Recall can change. What is clear is that respondent's records were not adequate or complete and therefore not helpful in reconstructing what actually was said and done.

50. On April 5, 2013, respondent submitted to the Office of Administrative Hearings a signed declaration under penalty of perjury that she had retained Monica Stokes, M.D. to be her expert on the K.S. case in April 2010 and that she had discussed K.S.'s treatment with her and had discussed her defenses to that case. This was at a time when there was no case pending against respondent concerning her treatment of K.S., but there was an investigation pending and the physician conference with the Board had just taken place. Dr. Stokes was retained to evaluate the K.S. case by the Board more than four months later. Dr. Stokes admits that she spoke to respondent in April 2010, about consulting with her on

her integrative medical practices, but denies discussing any specific case or specific Board investigation. Respondent and her counsel requested that Dr. Stokes be disqualified as an expert for the Board. While Dr. Stokes discussions give rise to a potential conflict of interest, she was allowed to testify. Although it appears that Dr. Stokes provided an unbiased written opinion, including some findings that were favorable to respondent, she exhibited bias when she testified, changing part of her opinion because she felt her integrity was attacked by the request to have her testimony excluded. While the better practice would have been for Dr. Stokes to recuse herself or for the Board to use a different expert, the use of Dr. Stokes was acceptable.

51. It was not established by clear and convincing evidence that respondent made false or misleading statements or that the statements she made constitute acts of dishonesty substantially related to the practice of medicine.

Other Matters

52. Respondent attended medical school and did her internship in India. After she came to the United States in about 1993, she did an internal medicine residency in Pennsylvania. She presently has a practice in Walnut Creek, California. She lists herself as "Internist/Geriatrician, Holistic Practitioner. She admits her record keeping was below the standard of practice. She attended the Medical Record Keeping Course given by the University of California, San Diego School of Medicine Continuing Education Program from April 25 - 26, 2013.

53. Taking into consideration all the evidence in this matter, it would not be against the public interest to allow respondent to continue to practice medicine under specific terms and conditions of probation as set forth below.

LEGAL CONCLUSIONS

1. By reason of the matters set forth in Findings 3 through 23, cause for disciplinary action exists in the case of K.S. pursuant to Business and Professions Code sections 2234, subdivision (b) (gross negligence), (c) repeated acts of negligence), and (d) (incompetence).

2. By reason of the matters set forth in Finding 24, cause for disciplinary action exists in the case of K.S. pursuant to Business and Professions Code section 2266 (failure to maintain adequate and accurate records.)

3. By reason of the matters set forth in Findings 25 through 44, cause for disciplinary action exists in the case of J.F. pursuant to Business and Professions Code sections 2234, subdivision (b) (gross negligence), (c) repeated acts of negligence), and (d) (incompetence).

4. By reason of the matters set forth in Finding 45, cause for disciplinary action exists in the case of J.F. pursuant to Business and Professions Code section 2266 (failure to maintain adequate and accurate records).

5. By reason of the matters set forth in Findings 46 through 51, it was not established by clear and convincing evidence that cause for disciplinary action exists pursuant to Business and Professions Code section 2234, subdivision (e) (dishonesty).

6. The matters set forth in Findings 52 and 53, have been considered in making the following order. This is consistent with Business and Professions Code section 2229, subdivision (b), which requires that disciplinary action should be "calculated to aid in the rehabilitation of the licensee, . . ." as long at the public can be protected. The terms and conditions of probation are designed to insure that respondent is safe to practice in California.

ORDER

Physician and Surgeon's Certificate No. A 67699 issued to respondent Suprabha Jain, M.D., is revoked. However, revocation is stayed and respondent is placed on probation for three (3) years upon the following terms and conditions:

1. Education Course

Within 60 calendar days of the effective date of this Decision, and on an annual basis thereafter, respondent shall submit to the Board or its designee for its prior approval educational program(s) or course(s) which shall not be less than 40 hours per year, for each year of probation. The educational program(s) or course(s) shall be aimed at correcting any areas of deficient practice or knowledge and shall be Category I certified, limited to classroom, conference, or seminar settings. The educational program(s) or course(s) shall be at respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure. Following the completion of each course, the Board or its designee may administer an examination to test respondent's knowledge of the course. Respondent shall provide proof of attendance for 65 hours of CME of which 40 hours were in satisfaction of this condition.

2. Medical Record Keeping Course

Within 60 calendar days of the effective date of this decision, respondent shall enroll in a course in medical record keeping, at respondent's expense, approved in advance by the Board or its designee. Failure to successfully complete the course during the first six months of probation is a violation of probation. Respondent's successful completion of the UC San Diego School of Medicine Medical Record Keeping Course completed on April 26, 2013, meets the requirements of this condition.

A medical record keeping course taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Board or its designee had the course been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the course, or not later than 15 calendar days after the effective date of the Decision, whichever is later.

3. Monitoring - Practice

Within 30 calendar days of the effective date of this Decision, respondent shall submit to the Division or its designee for prior approval as a practice monitor, the name and qualifications of one or more licensed physicians and surgeons whose licenses are valid and in good standing, and who are preferably American Board of Medical Specialties (ABMS) certified. A monitor shall have no prior or current business or personal relationship with respondent, or other relationship that could reasonably be expected to compromise the ability of the monitor to render fair and unbiased reports to the Division, including but not limited to any form of bartering, shall be in respondent's field of practice, and must agree to serve as respondent's monitor. Respondent shall pay all monitoring costs.

The Division or its designee shall provide the approved monitor with copies of the Decision(s) and Accusation(s), and a proposed monitoring plan. Within 15 calendar days of receipt of the Decision(s), Accusation(s), and proposed monitoring plan, the monitor shall submit a signed statement that the monitor has read the Decision(s) and Accusation(s), fully understands the role of a monitor, and agrees or disagrees with the proposed monitoring plan. If the monitor disagrees with the proposed monitoring plan, the monitor shall submit a revised monitoring plan with the signed statement.

Within 60 calendar days of the effective date of this Decision, and continuing throughout probation, respondent's practice shall be monitored by the approved monitor. Respondent shall make all records available for immediate inspection and copying on the premises by the monitor at all times during business hours and shall retain the records for the entire term of probation.

The monitor shall submit a quarterly written report to the Division or its designee which includes an evaluation of respondent's performance, indicating whether respondent's practices are within the standards of practice of medicine or billing, or both, and whether respondent is practicing medicine safely, billing appropriately or both.

It shall be the sole responsibility of respondent to ensure that the monitor submits the quarterly written reports to the Division or its designee within 10 calendar days after the end of the preceding quarter.

If the monitor resigns or is no longer available, respondent shall, within 5 calendar days of such resignation or unavailability, submit to the Division or its designee, for prior approval, the name and qualifications of a replacement monitor who will be assuming that responsibility within 15 calendar days. If respondent fails to obtain approval of a replacement monitor within 60 days of the resignation or unavailability of the monitor, respondent shall be suspended from the practice of medicine until a replacement monitor is approved and prepared to assume immediate monitoring responsibility. Respondent shall cease the practice of medicine within 3 calendar days after being so notified by the Division or designee.

In lieu of a monitor, respondent may participate in a professional enhancement program equivalent to the one offered by the Physician Assessment and Clinical Education Program at the University of California, San Diego School of Medicine, that includes, at minimum, quarterly chart review, semi-annual practice assessment, and semi-annual review of professional growth and education. Respondent shall participate in the professional enhancement program at respondent's expense during the term of probation.

Failure to maintain all records, or to make all appropriate records available for immediate inspection and copying on the premises, or to comply with this condition as outlined above is a violation of probation.

4. Notification

Prior to engaging in the practice of medicine the respondent shall provide a true copy of the Decision(s) and Accusation(s) to the Chief of Staff or the Chief Executive Officer at every hospital where privileges or membership are extended to respondent, at any other facility where respondent engages in the practice of medicine, including all physician and locum tenens registries or other similar agencies, and to the Chief Executive Officer at every insurance carrier which extends malpractice insurance coverage to respondent. Respondent shall submit proof of compliance to the Board or its designee within 15 calendar days.

This condition shall apply to any change(s) in hospitals, other facilities or insurance carrier.

5. Obey All Laws

Respondent shall obey all federal, state and local laws, all rules governing the practice of medicine in California and remain in full compliance with any court ordered criminal probation, payments, and other orders.

6. Quarterly Declarations

Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Board, stating whether there has been compliance with all the conditions of probation.

Respondent shall submit quarterly declarations not later than 10 calendar days after the end of the preceding quarter.

7. Probation Unit Compliance

Respondent shall comply with the Board's probation unit. Respondent shall, at all times, keep the Board informed of respondent's business and residence addresses. Changes of such addresses shall be immediately communicated in writing to the Board or its designee.

Under no circumstances shall a post office box serve as an address of record, except as allowed by Business and Professions Code section 2021, subdivision (b).

Respondent shall not engage in the practice of medicine in respondent's place of residence. Respondent shall maintain a current and renewed California physician's and surgeon's license.

Respondent shall immediately inform the Board or its designee, in writing, of travel to any areas outside the jurisdiction of California which lasts, or is contemplated to last, more than 30 calendar days.

8. Interview with the Board or its Designee

Respondent shall be available in person for interviews either at respondent's place of business or at the probation unit office, with the Board or its designee upon request at various intervals and either with or without prior notice throughout the term of probation.

9. Residing or Practicing Out-of-State

In the event respondent should leave the State of California to reside or to practice respondent shall notify the Board or its designee in writing 30 calendar days prior to the dates of departure and return. Non-practice is defined as any period of time exceeding thirty calendar days in which respondent is not engaging in any activities defined in sections 2051 and 2052 of the Business and Professions Code.

All time spent in an intensive training program outside the State of California which has been approved by the Board or its designee shall be considered as time spent in the practice of medicine within the State. A Board-ordered suspension of practice shall not be considered as a period of non-practice. Periods of temporary or permanent residence or practice outside California will not apply to the reduction of the probationary term. Periods

of temporary or permanent residence or practice outside California will relieve respondent of the responsibility to comply with the probationary terms and conditions with the exception of this condition and the following terms and conditions of probation: Obey All Laws and Probation Unit Compliance.

Respondent's license shall be automatically cancelled if respondent's periods of temporary or permanent residence or practice outside California totals two years. However, respondent's license shall not be cancelled as long as respondent is residing and practicing medicine in another state of the United States and is on active probation with the medical licensing authority of that state, in which case the two year period shall begin on the date probation is completed or terminated in that state.

Any respondent disciplined under B&P Code sections 141(a) or 2305 (another state discipline) may petition for modification or termination of penalty: 1) if the other state's discipline terms are modified, terminated or reduced; and 2) if at least one year has elapsed from the effective date of the California discipline.

10. Failure to Practice Medicine - California Resident

In the event respondent resides in the State of California and for any reason respondent stops practicing medicine in California, respondent shall notify the Board or its designee in writing within 30 calendar days prior to the dates of non-practice and return to practice. Any period of non-practice within California, as defined in this condition, will not apply to the reduction of the probationary term and does not relieve respondent of the responsibility to comply with the terms and conditions of probation. Non-practice is defined as any period of time exceeding thirty calendar days in which respondent is not engaging in any activities defined in sections 2051 and 2052 of the Business and Professions Code.

All time spent in an intensive training program which has been approved by the Board or its designee shall be considered time spent in the practice of medicine. For purposes of this condition, non-practice due to a Board-ordered suspension or in compliance with any other condition of probation, shall not be considered a period of non-practice.

Respondent's license shall be automatically cancelled if respondent resides in California and for a total of two years, fails to engage in California in any of the activities described in Business and Professions Code sections 2051 and 2052.

11. Completion of Probation

Respondent shall comply with all financial obligations (e.g., restitution, probation costs) not later than 120 calendar days prior to the completion of probation.
Upon successful completion of probation, respondent's certificate shall be fully restored.

12. Violation of Probation

Failure to fully comply with any term or condition of probation is a violation of probation. If respondent violates probation in any respect, the Board, after giving respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If an Accusation, or Petition to Revoke Probation, or an Interim Suspension Order is filed against respondent during probation, the Board shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

13. License Surrender

Following the effective date of this Decision, if respondent ceases practicing due to retirement, health reasons or is otherwise unable to satisfy the terms and conditions of probation, respondent may request the voluntary surrender of respondent's license. The Board reserves the right to evaluate respondent's request and to exercise its discretion whether or not to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the surrender, respondent shall within 15 calendar days deliver respondent's wallet and wall certificate to the Board or its designee and respondent shall no longer practice medicine. Respondent will no longer be subject to the terms and conditions of probation and the surrender of respondent's license shall be deemed disciplinary action. If respondent re-applies for a medical license, the application shall be treated as a petition for reinstatement of a revoked certificate.

14. Probation Monitoring Costs

Respondent shall pay the costs associated with probation monitoring each and every year of probation, as designated by the Board, which may be adjusted on an annual basis. Such costs shall be payable to the Medical Board of California and delivered to the Board or its designee no later than January 31 of each calendar year. Failure to pay costs within 30 calendar days of the due date is a violation of probation.

DATED: September 20, 2013

Ruth S. Astle

RUTH S. ASTLE
Administrative Law Judge
Office of Administrative Hearings

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BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **SUPRABHA JAIN, M.D.** **Mt. Diablo Integrated Wellness Center** **325 North Wiget Lane, Suite 130** **Walnut Creek, CA 94598** **Physician and Surgeon's Certificate No. A67699** Respondent.	Case No. 12-2009-197864 **SECOND AMENDED ACCUSATION**

Complainant alleges:

PARTIES

1. Kimberly Kirchmeyer (Complainant) brings this Accusation solely in her official capacity as the Interim Executive Director of the Medical Board of California, Department of Consumer Affairs.

2. On or about March 5, 1999, the Medical Board of California issued Physician and Surgeon's Certificate Number A67699 to Suprabha Jain, M.D. (Respondent). Unless renewed, this Certificate will expire on March 31, 2015.

JURISDICTION

3. This Accusation is brought before the Medical Board of California (Board), Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

4. Section 2004 of the Code states:

"The board shall have the responsibility for the following:

"(a) The enforcement of the disciplinary and criminal provisions of the Medical Practice Act.

"(b) The administration and hearing of disciplinary actions.

"(c) Carrying out disciplinary actions appropriate to findings made by a panel or an administrative law judge.

"(d) Suspending, revoking, or otherwise limiting certificates after the conclusion of disciplinary actions.

"(e) Reviewing the quality of medical practice carried out by physician and surgeon certificate holders under the jurisdiction of the board.

"(f) Approving undergraduate and graduate medical education programs.

"(g) Approving clinical clerkship and special programs and hospitals for the programs in subdivision (f).

"(h) Issuing licenses and certificates under the board's jurisdiction.

"(i) Administering the board's continuing medical education program."

5. Section 2227 of the Code provides that a licensee who is found guilty under the Medical Practice Act may have his or her license revoked, suspended for a period not to exceed one year, placed on probation and required to pay the costs of probation monitoring, or such other action taken in relation to discipline as the Division deems proper.

6. Section 2234 of the Code states:

"The Division of Medical Quality[1] shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

"(a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter [Chapter 5, the Medical Practice Act].

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[1] "Division of Medical Quality" shall be deemed to refer to the Medical Board of California. (Bus. & Prof. Code §2002)

"(b) Gross negligence.

"(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

"(1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.

"(2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.

"(d) Incompetence.

"(e) The commission of any act involving dishonesty or corruption which is substantially related to the qualifications, functions, or duties of a physician and surgeon.

"(f) Any action or conduct which would have warranted the denial of a certificate."

7. Section 2234.1 of the Code states, in pertinent part:

"(a) A physician and surgeon shall not be subject to discipline pursuant to subdivision (b), (c), or (d) of section 2234 solely on the basis that the treatment or advice he or she rendered to a patient is alternative or complementary medicine . . . if that treatment or advice meets all of the following requirements:

"(1) It is provided after informed consent and a good faith prior examination of the patient, and medical indication exists for the treatment or advice or it is provided for health or well-being.

"(2) It is provided after the physician and surgeon has given the patient information concerning conventional treatment and describing the education, experience, and credentials of the physician and surgeon related to the alternative or complementary medicine that he or she practices.

"(3) In the case of alternative or complementary medicine, it does not cause a delay in, or discourage traditional diagnosis of a condition of the patient.

"(4) It does not cause death or serious bodily injury to the patient.

"(b) For purposes of this section, 'alternative or complementary medicine' means those health care methods of diagnosis, treatment, or healing that are not generally used but that provide a reasonable potential for therapeutic gain in a patient's medical condition that is not outweighed by the risk of the health care method."

8. Section 2266 of the Code states: "The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct."

9. The events described in the First and Second Causes for Discipline occurred in 2009 and involve respondent's treatment of K.S.[2], a 60 year old female. The events described in the Third and Fourth Causes for discipline occurred from November 2005 through June of 2007 and involve respondent's treatment of J.F., a 51 year old male. Respondent heads an integrative medicine group practice at Mt. Diablo Wellness Center, Inc. (MDI), FNP 31146, which employs methods based primarily on Ayurvedic medicine. (See Appendix, attached hereto.)

10. Respondent describes her practice as consisting of several modalities, including intravenous (IV) vitamin/mineral infusions, usually employing Meyers' Cocktail, colon irrigations utilizing an FDA-approved device, and dark field microscopy for "patient awareness" purposes and not for diagnosis *per se*. She also occasionally provides EDTA chelation therapy for chelation of environmental toxins administered along with IV Meyer's Cocktail, but not for patients with heart disease. She uses "spiritual guidance" based on the teachings of her personal "Master Teacher" from India, and she freely shares these teachings with her patients. She uses a form of guided imagery that includes breath awareness. She offers lodging at her home for patients that come from long distances or patients that need particularly intensive treatment. She uses laboratory equipment in her clinic (microscopes, autoclave, centrifuge, etc.) that is not CLIA (Clinical Laboratory Improvement Act) or California State approved; she employs no one trained or responsible for maintaining or calibrating this equipment.

11. Respondent apparently has no formal training or resultant degrees or certificates in integrative medicine or Ayurvedic Medicine. She describes herself as "self-trained" and distantly monitored by Dr. Frank Shallenberger for dark field microscopy/live blood analysis and that sheets describing Live Blood Evaluation which she uses to educate her patients were obtained from an unlicensed natural medicine practitioner. Respondent indicates she does not know a lot

[2] Initials are used to protect patient privacy. Respondent will be provided with the full name of the patient pursuant to any Request for Discovery.

about this field or even a belief in the teachings. Respondent uses biofeedback equipment, but it is unclear for what purpose this is employed except to determine where the patient fits into the general ranges identified on the biofeedback sheet; it is not apparently employed for purposes of diagnosis or patient treatment. Respondent states that she uses her own knowledge base to determine whether a patient's pharmaceutical treatment would interact with the herb preparations she prescribes; she is unaware of any authoritative reference concerning herb-drug interactions. She sells certain herb combinations and an energy drink to patients as part of treatment.

FIRST CAUSES FOR DISCIPLINE

(Gross Negligence/Negligence/Incompetence – Patient K.S.)

12. K.S. first consulted respondent at MDI on or about January 4, 2009. K.S. had had issues with anxiety, depression, and pain since she was 28 years old. She had consulted an acupuncturist and a chiropractor, and during the time she consulted respondent, she was also being prescribed for by an integrative pain management clinic in Concord, California. K.S. suffered from chronic neck and low back pain; her weight was 210 pounds; and she complained of always being cold and sleeping 14 hours a day. She indicated on her MDI patient information sheet that her reason for consulting respondent was "sweats and muscle spasm."

13. K.S. reported that in the previous year, she had decided to reduce the dosages of or eliminate the number of drugs she was taking. Her drugs[3] had included Advair, albuterol, Xanax, Dilaudid, Oxycodone, Effexor, Abilify, Klonopin, and a stool softener. She had been reducing or eliminating her drugs by herself without consistent medical supervision and had apparently eliminated all drugs except for Klonopin and fentanyl patches at the time she consulted respondent. She said she had indicated to her pain management physician that she wished to eliminate the fentanyl patch as well.

14. When K.S. began suffering from sweats and nausea, her son recommended respondent's clinic. K.S.' mother had been respondent's patient previously and had $5000.00 in unapplied deposits reserved for her at MDI. K.S. called MDI and was able to obtain an

[3] Please see Appendix attached hereto for definitions of integrative medicine concepts and of prescription drugs involved in this action.

appointment with respondent for the next day, January 4, 2009. K.S. filled out a patient information sheet and was examined by respondent. Respondent recognized that K.S. was suffering the effects of narcotics/controlled substance withdrawal.

15. Respondent developed a "medical model" form for intake history and physical. On January 4, 2009, K.S. filled out the first page of such a patient information form; the second page was left blank. Respondent recorded a brief medical history of K.S. in her progress notes and recorded vital signs. After this point in the treatment of K.S., there are no other vital sign readings recorded. Respondent had laboratory tests performed on K.S., including a complete blood count (CBC), urinalysis, chemistry panel, and toxicology screen. All laboratory values were within normal limits, and the toxicology screen was negative, even for benzodiazepines, such as Klonopin, or opiates, such as fentanyl. During K.S.' treatment, no repeat laboratory tests were ordered or performed.

16. On January 5, 2009, K.S. signed her payment agreement and had the program of treatment explained to her, which included live blood cell analysis, "full body" detoxification, Ayurvedic yoga therapy, healthy cooking, meditation, bioresonance sessions, and IV vitamins and chelation as needed. K.S. was apparently provided with some hand-outs describing the purposes behind the therapies, general principles and guidelines of Ayurvedic therapies, a healthy cooking food menu, the Ayurvedic toxin-elimination regimen, and live blood evaluation pictorial worksheets. Respondent filled out a history and physical form which included information about K.S.' current medications, which were fentanyl patch and Klonopin; and her current symptoms, which included excessive sweating, anxiety, severe neck pain, overweight, sleeplessness, and drug withdrawal. No vital signs were recorded on the physical examination portion. This form included a nutritional intake evaluation, wherein the patient's usual diet was recorded.

17. Respondent described her mode of medical practice as primarily including a spiritual aspect, where the patient's mind, body, and spirit are involved. She developed a body constitution questionnaire for this aspect, wherein the patient assesses his or her general state of mind and body. K.S. filled out this form on January 5, 2009. Respondent states that she believes this aspect of treatment requires connecting and bonding with the patient and that there are no

templates for documentation of this kind of work. Also on January 5, 2009, K.S. presented respondent with a tapering schedule for her drugs; and respondent provided K.S. with a cleansing/rejuvenating diet to follow. Also on that day, K.S. received a colon cleansing assessment in which a severely impacted bowel was found and colonic irrigation was scheduled. K.S. also received a therapeutic breathing treatment on January 5th and again on January 7th and January 9th. Respondent discontinued K.S.' stool softener and prescribed Libidex cream and other herbal medications.

18. K.S. expressed her desire to self-taper her fentanyl and Klonopin usage, and respondent indicated later that saw her role in this process as supportive, facilitating what the patient wants for himself or herself, not determining what the doctor wants for the patient. Respondent explained later that she saw her role not as directing or controlling K.S.' withdrawal from narcotics and controlled substances, but as supporting the patient's restoration to health while she withdrew from drugs and to first purge her system of impurities. K.S. told respondent that she was only using 1 mg. Klonopin *t.i.d.* and fentanyl patch 50 mcg every three (3) days. Respondent did not at any time consult with K.S.' pain management physicians, coordinate care, or assure the safety of K.S' self-directed method or speed of drug detoxification, nor did she obtain a medical records release from K.S for the prescribers of K.S.' medications to determine the actual course of K.S.' pain treatment..

19. On January 6, 2009, K.S. brought into respondent a copy of a radiology report on films taken of her lumbar spine a year before for her pain management physician. She also brought in a copy of her chiropractic treatment records, with the latest notation being earlier that day. K.S. filled out another patient information sheet with insurance and employer information, prior and concurrent medical treatments, and description of the pain she currently suffered. Respondent performed colonic irrigation on K.S., which did not work at first because of the impacted bowel, so after the third treatment, respondent performed manual disimpaction of what she called "rocks" in K.S.' colon, and the bowel was finally cleared. Respondent prescribed more fiber and warm water intake in addition to herbal remedies.

20. K.S. underwent oil treatments, cognitive training for pain, counseling, and breathing exercises throughout her treatment. She was also placed on a liquid diet of vegetable and broth puree and various powders and herbs for Ayurvedic cleansing and treatment. Respondent also prescribed or administered purgatives, such as castor oil. No treatment plan is noted in K.S.' records and there are no follow up notes indicating the efficacy of the treatments. K.S. experienced increasing nausea with the herb treatment, which eased somewhat after she began taking herself off of them. After approximately two weeks on this treatment, K.S. became increasingly nauseous and weak with fatigue, with the purgatives further enervating her.

21. By January 14, 2009, respondent noted that K.S. was "tired and dehydrated," and she was given intravenous (IV) vitamin treatment. It is unclear from the record that this IV vitamin and mineral solution was Meyer's cocktail or whether EDTA was or was not added. On January 15, 2009, it is noted in the record that K.S. experienced a catatonic episode which included an inability to speak. Respondent noted there was a question of drug withdrawal and stress. K.S. filled out a stress evaluation questionnaire and a holistic stress evaluation via biofeedback.

22. On January 16, 2009, K.S. reported extreme fatigue, insomnia, and diarrhea. Respondent again administered IV treatment with a vitamin and mineral solution; it is again unclear from the record that this solution was Meyer's cocktail or whether EDTA was or was not added. On January 17, 2009, respondent made a house call on K.S. because she was too weak to go into the clinic. Insomnia, extreme fatigue, and nausea had reached their peak. K.S. later described this state as feeling as if she was going to die. Respondent recommended fluids and supplements with a slowly advancing vegetable diet, as well as an over-the-counter anti-emetic. She noted that K.S.' drug dependence/withdrawal was still fluctuating, but with more "better" moments. She documents a "long talk" with K.S. about her past traumas and emotional stressors. At no time did respondent recommend that K.S. be taken to a hospital emergency room, contact K.S.' primary care physician or pain management physician, or order further laboratory tests to determine K.S.' state of health..

23. Respondent saw K.S. at MDI on January 20, 2009. Respondent notes loss of weight, night sweats, and loss of sleep. She again notes K.S.' plan to discontinue fentanyl and minimize

Klonopin intake. She notes that bowel movements are normal. Her diagnosis is weight loss, sleep disorder, anxiety, depression, bipolar, drug dependence, neck and back pain. Her plan is for diet and lifestyle change, staying on a soft diet, continuing the tapering of drugs, and consulting a chiropractor or physical therapist for pain. Respondent did not refer K.S. to her primary care physician or pain management physician or suggest a mental health evaluation.

24. K.S. consulted respondent on January 21, 2009. Respondent's notes indicate that K.S. has reduced the fentanyl patch and that she complains that her whole body aches and she is tired, that she has constant diarrhea, feels weak, and is dehydrated. Respondent notes drug withdrawal and that the patient seems to be going through personality/behavioral changes. Respondent apparently recommended an herb preparation. Respondent did not refer K.S. to her primary care physician or pain management physician or suggest a mental health evaluation.

25. On or about January 25, 2009, K.S. left a voicemail message for respondent reporting her continuing physical distress, and respondent recommended that she see another physician for her physical symptoms. On January 26, 2009, after her prolonged period of diarrhea, K.S. went to the emergency room at John Muir Hospital and was given IV electrolytes and Zofran with a prescription for Imodium. Thereafter, K.S. discontinued her treatment with respondent and sought out an addiction specialist for her drug withdrawal. As of February 2009, she was being weaned off of fentanyl and Klonopin with a plan for maintenance treatment with suboxone.

26. It is unclear from respondent's records for K.S. whether respondent applied any of the information gained from laboratory tests done, the history and physical examinations done, or the symptoms reported to any of the treatments administered or prescribed for K.S.

27. Respondent is subject to disciplinary action under section 2234(b), (c) and/or (d) of the Code by reason of the following acts or omissions:

A. Respondent failed to appreciate or determine the degree of illness caused by K.S.' self-directed drug detoxification process and proceeded with her treatments despite the potential to exacerbate or not to alleviate K.S.' illness. In the face of medical evidence that supportive alternative treatment was insufficient to alleviate or treat K.S.' illness, respondent continued alternative treatment without regard to empirical laboratory results, various questionnaires

concerning patient state of mind, symptoms, observations, concurrent treatments, complaints and other data. In addition, after K.S. manifested increasing illness, respondent continued alternative treatment without repeating laboratory tests or retaking vital signs to determine any changes in the patient's medical status that may have required a change in treatment.

B. Respondent failed to educate herself or seek consultation concerning the factors to consider in dealing with drug dependency, detoxification, and withdrawal and ascertaining if there were any special considerations necessary before employing alternative remedies.

C. Respondent failed to consult with K.S.' other treating practitioners to integrate her alternative treatments with knowledge of concurrent therapies, diagnoses, and assessments by other professionals and coordination of treatment in light of that knowledge.

D. Respondent continued colonic irrigation, purgatives, and other herbal remedies with unknown side effects in the face of the patient's obvious physical deterioration, manifested by diarrhea, nausea, enervation, dehydration, and muscle weakness.

E. Respondent failed to refer K.S. to a hospital emergency room or consult her primary care physician on January 17, 2009, when respondent had to make a house call to K.S. because she was too ill to travel to MDI. Respondent should have recognized K.S. symptoms as signs of dehydration and electrolyte imbalance, especially knowing that K.S. had been administered purgatives and enemas and had had gastrointestinal problems throughout respondent's treatments.

F. Respondent utilized modalities of Ayurvedic medicine and other alternative medical therapies without a consistent therapeutic approach or plan and without assessment as to efficacy or individual application. Although respondent did employ allopathic modes of ascertaining health status, such as laboratory tests, she employed them without application of the results to her treatment of K.S. Several alternative therapies were applied with no coherent individual treatment plan.

G. Respondent failed to employ integrative medicine approaches, to utilize her experience and training in allopathic medicine to inform her treatment of K.S. and assessing when allopathic approaches should be considered. For example, when supportive alternative treatment of K.S.' self-directed drug detoxification was insufficient to alleviate K.S.' withdrawal symptoms

and may have exacerbated K.S.' symptoms, this failure on respondent's part could have caused other serious medical conditions. Respondent failed to utilize her education and training to ascertain when to discontinue alternative treatment for a medical approach or to integrate allopathic practices into her treatment of K.S.

H. Respondent provided no detailed informed consent to K.S., written or documented, such that K.S. fully understood Ayurvedic approaches to treatment. K.S. did not know that the *panchakarma* process may entail her getting worse before she gets better; K.S. did not understand or provide informed consent that respondent's treatment was not intended to treat her physical symptoms or her detoxification process; K.S. did not know the purposes for the various herbal remedies employed. K.S. sought treatment to alleviate the symptoms of her drug withdrawal.

I. Respondent has had no formal training in Ayurvedic Medicine or other alternative therapies or in Integrative Medicine. She has established a clinic which utilizes certain parts of these therapies without coherent application based on thorough training, experience, and understanding. For instance, respondent apparently understands that dark field microscopy/live blood cell analysis has been discredited as a diagnostic tool, but she still employs it in her practice for "patient education." She provided K.S. with a handout depicting several cell "abnormalities" and the diagnoses such findings would represent, thus at least implying that this was a diagnostic tool and misleading the patient. Respondent failed to provide the constant monitoring necessary to provide Ayurvedic treatment such as preparing and feeding the patient clean foods, providing analysis of the patient's *doshas* or providing for and modeling change in the patient's lifestyle. Respondent seems to have very little understanding of the bases for the modalities of alternative treatments she employs and their use in the individual treatment of a patient. Respondent's employment of allopathic medicine diagnostic modalities, in which she has been trained, appears to have no connection with her treatment of the patient.

J. When respondent noted possible mental health diagnoses for K.S., such as bipolar disorder, sleep disorder, anxiety and depression, she documented no basis for these diagnoses,

and failed to refer K.S. for mental health treatment, confer with K.S.' other treating physicians, or speak to K.S. about her concerns.

K. K.S. eventually received effective treatment for drug detoxification and withdrawal symptoms, but traditional effective treatment of K.S.' individual strong reaction to drug withdrawal, and to ineffective self-directed detoxification efforts, was delayed due to respondent's treatment and approach, which delayed the discovery of the need for such treatment.

SECOND CAUSE FOR DISCIPLINE

(Inaccurate/Inadequate Recordkeeping – Patient K.S.)

28. The allegations of the First Cause for Discipline are incorporated herein by reference, as if fully set forth.

29. Respondent is subject to disciplinary action under section 2266 of the Code by reason of the following acts or omissions:

A. Notations in the records are sketchy and often illegible.

B. Respondent's progress notes contain very little information besides the patient's report of her state of health or complaints. No vital signs are recorded, except for the initial visit. No assessment is noted. No awareness of the patient's physical condition and its connection to her underlying medical condition or to respondent's treatment is documented. No treatment plan, ongoing or otherwise, is noted.

C. Respondent, who is employing alternative medicine, provides no detailed description of the modalities employed, the application to the patient, or the basis for the treatment. No components of herbal preparation, or, if prepackaged, the manufacturer, dosage, duration, or indication are set forth in the record.

D. Respondent's records for K.S. provide very little information concerning the connection between each modality employed, the advice given, the individual condition of the patient, and the outcome sought.

E. Respondent documents no detailed informed consent given to K.S. or that K.S. was given any information concerning conventional treatment or describing the education, experience and credentials of respondent related to the alternative medicine that she practices.

THIRD CAUSES FOR DISCIPLINE

(Gross Negligence/Negligence/Incompetence – Patient J.F.)

30. Patient J.F. first consulted respondent in February of 2003, when he and his wife, S.F., were seeking a new primary care physician (PCP), or M.D. internist to act in that capacity, as theirs had retired. Respondent was initially consulted by J.F. for an upper respiratory tract infection. In March 2003, respondent referred J.F. to Alba Bates ER for a foot fracture, but did not see him in her office.

31. J.F. next saw respondent on October 21, 2005, at which time he complained of knee pain, hip pain due to osteoarthritis of the left hip, as well as anxiety and stress. He had declined a hip replacement at that time. *J.F. also complained of groin pain, which respondent attributed to his hip disease.* Respondent ordered supplements, recommended stress management measures (meditation), and ordered x-rays of the hip and knee. The x-rays were followed later by MRI's, received in November of 2005, which confirmed degenerative changes and other problems.

32. J.F.'s next visit with respondent was on November 1, 2005. J.F. complained of worsening left hip and knee pain and a stressful family situation. Respondent diagnosed hip and knee pain, stress and anxiety, insomnia, and fatigue. She discussed sleep hygiene measures with J.F. and made a note to check MRI results. She noted results of a "dark field microscopy" examination. Respondent recommended that J.F. keep a food diary. Respondent ordered a complete blood count (CBC) and comprehensive metabolic panel (CMP) for J.F, as well as PSA alkaline phosphatase and homocysteine.levels.

33. On November 3, 2005, J.F. consulted respondent for a "stress evaluation," and respondent noted that J.F. suffered from chronic pain and insomnia. Examination notes indicated a shorter left leg and reduced hip range of motion (ROM). Respondent noted that no genital or prostate examination was done. Respondent recommended biofeedback (which was done on November 3rd and November 10th) and electrical stimulation for pain relief. She noted discussions of diet, weight loss, stress reduction, and regular exercise. J.F. was seen on November 8th and November 11th for hip pain treatments, and on November 11th, respondent entered diagnoses of hip and knee degenerative joint disease (DJD) with pain, and she

recommended biofeedback and continued electrical stimulation treatments. On November 15th, further knee and hip pain treatments for J.F. were noted.

34. Samples for J.F.'s CBC and CMF, and other tests were drawn and received by the laboratory on November 12, 2005. The results were reported on November 17, 2005. The results indicated a *mildly elevated prostate specific antigen (PSA) level of 5.1 ng/dl (normal range: < or = 4.0 ng/dl)* and a normal alkaline phosphatase level of 89 U/L (normal range: 20-125 U/L), as well as elevated cholesterol and homocysteine levels. Respondent did not obtain records of J.F.'s previous PCP to compare any previous tests. J.F. saw respondent on November 17, 2005, and she noted DJD of the hip and knee and also "high homocysteine," and "Abnl Labs," indicating that she had received and read the laboratory results. There is no indication in J.F.'s chart that respondent discussed the abnormal laboratory findings with J.F., performed a prostate examination or referred J.F. for such an examination. No follow up plan was noted.

35. Respondent avers that she repeatedly discussed the elevated PSA with J.F. and that she asked him to arrange for a repeat PSA test and even referred him to a urologist, but J.F. did not follow her directions. However, these alleged discussions and refusals are nowhere noted in J.F.'s chart, and there is no further laboratory order for a PSA test or a notation of a referral to a urologist. J.F. and his wife aver that they knew nothing of the significance of an elevated PSA level until May 2007, when another practitioner consulted for rib pain ordered a CBC and CMA including PSA and alkaline phosphatase.. Respondent noted at her physician conference with the Board that she did not see the mild PSA elevation as "a big deal" and did not want to panic J.F. unnecessarily, as he was "antagonistic to anything medical." J.F. had submitted before, without protest, to x-rays, MRI's, and blood and urine testing, and he readily consulted physicians to whom respondent referred him for other ailments. For the November 17th visit, respondent notes recommendations for several supplements and the restarting of pain relief treatments.

36. J.F.'s final visit with respondent in 2005 occurred on December 8th. Respondent noted J.F.'s hip pain was improved after the recommended treatments, and respondent recommended continuing them. The abnormal PSA result was available to respondent on November 17, 2005. There is no chart documentation at any office visit on or after November 17,

2005 that there was any discussion with J.F. about his abnormal PSA level or any plan for follow up tests, treatments, or referrals for dealing with that abnormal level.

37. In March 2006, J.F. saw respondent after he was in a motor vehicle accident (MVA) and sustained a back injury; he had had several chiropractic treatments for the injury before consulting respondent. J.F. complained mostly about the continuing and worsening of his left hip and knee pain, which had been exacerbated by the MVA. Respondent recommended massage and acupuncture by "Adam," an acupuncture practitioner associated with her practice, and neuromuscular rehabilitation, by David S., TCMD (China), a QiGong expert associated with her practice. Respondent received reports of the neuromuscular rehabilitation treatments, which took place on March 28, and April 6, 13, 20, and 27, 2006 and initialed each of the reports, indicating she had read them. In the April 20, 2006 report, David S. indicates *"Pt. now (1st time) states there's pain in the groin now."*(Emphasis added.) J.F. had last complained of groin pain at a patient visit with respondent on October 21, 2005, before the CBC and CMF were ordered or obtained, which respondent had attributed to J.F.'s hip disease.

38. By the next visit with respondent on May 1, 2006, J.F. apparently reported that he was almost back to normal; he had occasional back spasms, but the exacerbation of hip pain had been resolved. Respondent concluded that no more treatments were needed for these conditions and discussed lifestyle with J.F. During June and July of 2006, J.F. continued acupuncture treatments at respondent's clinic, and reports of these treatments were initialed by respondent, but the name of the practitioner administering the treatments is not mentioned. The acupuncture treatment reports contain no notation of patient condition, response, tongue or pulse evaluation or reason for the treatments.

39. J.F.'s next visit with respondent was on July 25, 2006 and entitled "f/u from Adam." Respondent indicates J.F. reported a 25% improvement in hip and knee pain following treatments from "Adam" along with some homeopathy. Respondent recommended continued treatments.

40. The last visit of 2006 was on August 28th, when J.F. complained of eye pain after a trauma. Noting no bruising or tearing, respondent noted that she reassured him and said he could see an ophthalmologist. Respondent also referred J.F. to an ENT practice for evaluation of a six-

month long hearing loss that J.F. reported. A report by the ENT physician to respondent indicating a visit in late September 2006, indicated mild hearing loss and recommended scheduling a neurodiagnostic study to rule out retrocochlear pathology. There is no indication in respondent's chart for J.F. that this was ordered or done.

41. J.F.'s next visit to respondent was in February 2007, when *he complained of chest wall pain* as well as the fact that his knee and hip pain had returned when he stopped his treatments. *Respondent noted his back and right rib/chest pain and attributed it to chondrocondritis with no etiology noted.* She recommended work with "Adam." A notation in the margin for this visit indicated "referred to MME Rx-Tucson." At her physician conference with the Board, respondent denied that she had referred J.F., but that this was a magnetic treatment for which J.F. had requested a referral to help his joint pain.

42. "Adam" performed acupuncture and massage for J.F. for back, hip, and knee pain in February 26 and March 1, 2007, and *he noted not only left hip and knee pain but also right rib chest pain.* These notes were not initialed by respondent.

43. J.F. and his wife visited family in Connecticut in May 2007. On May 16, 2007, he consulted a chiropractor there, Michael M., D.C., for back pain. Dr. M. did manipulative therapy, but he also was concerned about J.F.'s reports of a recent increase in chest and abdominal pain, so he ordered an abdominal ultrasound to rule out gall bladder disease and lab work that included a PSA level. Lab results indicated *a significant elevation in PSA to 182.1 ng/dl (normal range: 0.0 to 4.0 ng/ml)*, as well as elevated triglycerides, cholesterol, and an *alkaline phosphatase level of 329 U/L (normal level40-115 U/L)*, up from 89 in 2005. The laboratory sent a copy of the laboratory results to respondent's clinic. He recommended to J.F. that he see a urologist for evaluation immediately upon his return to California. J.F. consulted a retired urologist friend of S.F.'s brother in Connecticut, who did a digital rectal examination (DRE) and found suspicious hardening and nodules on the prostate, and he recommended a biopsy.

44. J.F. left a message for respondent concerning his high PSA level and his fears of prostate cancer. J.F. and S.F. immediately began a search for a formal urological consult, and made an appointment for evaluation and biopsy at the University of California San Francisco

Medical Center (UCSF) five days before J.F.'s June 1, 2007 appointment with respondent. In her notes of the June 1, 2007 appointment, respondent noted that a DRE had been done.

45. At his June 1, 2007 appointment with respondent, J.F. shared the lab results obtained by Michael M. in Connecticut, and respondent notes that his PSA was greater than 100. In addition, respondent noted "awaiting biopsy." Respondent also noted stress and anxiety; abdominal pain of "unknown" etiology, and hip DJD. Respondent noted recommendations for stress reduction, a CT scan of the chest and abdomen and "biopsy prostate." No laboratory orders for these procedures or laboratory reports are present in J.F.'s chart, and no referrals are noted. However, there is a copy in J.F.'s chart of radiology results dated May 27, 2007 ordered by "unknown," but S.F. revealed as James O, D.C., the family chiropractor, whom J.F. had seen on Ma6 24th. These results were apparently faxed to respondent, and indicated a pleural based soft tissue mass along the right lateral mid chest and recommending a CT scan of the chest.

46. According to respondent's medical records for J.F., at an appointment on June 4, 2007, J.F. completed another Stress Evaluation Biofeedback Questionnaire (First Questionnaire done November 3, 2005), and he noted on that form for the first time that *he had "urinary or growth problems."* Respondent noted *"chest wall pain; abnormal labs;* Left hip pain." (Emphasis added.) She recommended Tylenol and additional neuromuscular rehabilitation treatments. According to J.F. and S.F., J.F.'s last face-to-face appointment with respondent was on June 1, 2007, and the biofeedback questionnaire was filled out then.

47. Follow up PSA and alkaline phosphatase levels, ordered by respondent at J.F.'s request, were taken on June 26, 2007 and indicated a further elevation of PSA to 234 ng/ml and of alkaline phosphatase to 442 U/L. By this time, J.F. and S.F. had instituted medical treatment for him at UCSF. A biopsy taken there on July 5, 2007 indicated Stage IV prostatic adenocarcinoma.

48. Respondent is subject to disciplinary action under section 2234(b), (c), and/or (d) of the Code by reason of the follow acts or omissions:

A. As a primary care physician (PCP) and/or as a treating physician ordering and receiving laboratory results indicating an abnormal PSA level in November 2005, respondent

failed to follow up on that result by explaining and discussing it and other abnormal results with the patient, ordering a repeat test, referring J.F. to a specialist, or doing a digital rectal examination herself. As soon as any physician orders routine laboratory work or screening studies for a patient, he or she is professionally obligated for the interpretation, evaluation, counseling and follow up care or he or she must refer the patient to another physician for appropriate evaluation and care.

B. Respondent's treatment of J.F. focused on stress, sleep, and knee/hip pain and her laboratory testing was non-specific, consisting of such tests as biofeedback and dark field microscopy, none of which could provide findings indicating the presence of a major medical illness such as prostate cancer or provide follow up information on the elevated PSA level.

C. Respondent never followed up on the initial elevated PSA level for J.F., even after he reported groin pain in October 2005, prior to the initial PSA test in November 2005, groin pain in April 2006, and groin and chest pain in early 2007. She attributed these symptoms to hip problems and condrochondritis in the face of evidence in her own record that PSA levels were elevated more than a year earlier. Groin pain and particularly chest pain can be symptoms of prostate cancer and metastatic disease.

D. Respondent was ignorant of, or lacked the knowledge or ability to appreciate, the importance of follow up on the initial elevated PSA finding for J.F. She had multiple visits with J.F. over one and a half years, and she never discussed the potential implications and need for follow up with J.F. or his wife. Even after the second PSA level was obtained by Dr. Michael M. in Connecticut, she documented no referral to a urologist, nor did she order a biopsy or any other diagnostic test. J.F. had to request that respondent order a repeat PSA test on June 25, 2007.

E. Respondent failed to employ integrative medicine approaches to J.F.'s care. She failed to use her experience and training in allopathic medicine to inform her treatment of J.F. Although she ordered a CBC and CMP in November of 2005, she failed to follow up on abnormal findings through allopathic medicine, and instead, she focused on alternative treatments that were inadequate to diagnose or treat the abnormalities found on laboratory testing. She failed to note that the symptoms displayed by J.F., such as groin pain and chest pain could have been connected

to elevated PSA values and did not perform a complete examination or make a differential diagnosis. Even when confronted with grossly elevated PSA levels and alkaline phosphatase levels ascertained by another practitioner, respondent continued to prescribe alternative remedies instead of ordering appropriate tests, obtaining a CT scan, or ordering a biopsy or at least assuring that appropriate treatment had been initiated by others.

F. Respondent utilized modalities of Ayurvedic medicine and other alternative medical therapies without a consistent therapeutic approach or plan and without assessment as to efficacy or individual application. Although respondent did employ allopathic modes of ascertaining health status, such as laboratory tests, she employed them without application of the results to her treatment of J.F. Several alternative therapies were applied with no coherent individual treatment plan.

FOURTH CAUSE FOR DISCIPLINE

(Inaccurate/Inadequate Record Keeping – Patient J.F.)

49. The allegations of the Third Cause for Discipline are incorporated herein by reference as if fully set forth.

50. Respondent is subject to discipline under section 2266 of the Code by reason of the following acts or omissions:

A. Respondent claims that she was not J.F.'s PCP, but she has no documented verbal or written agreement that made it clear that she did not intend to be J.F.'s PCP. Even if she did not consider herself J.F.'s PCP, she apparently did not document an inquiry as to whether he was seeing another physician as PCP, and she never indicated in J.F.'s records any inquiry as to whether J.F. himself had followed up with any practitioner concerning the abnormal PSA result of November 2005, nor did she indicate a referral to a urologist or other specialist for follow up.

B. Respondent did not document in J.F.'s chart any particular concern about J.F.'s elevated PSA level in November 2005, nor did she document the initial abnormal result in the physician's progress notes. She did not document that she ever asked J.F. to repeat the test. If she was having difficulty convincing J.F. to repeat the test, it was not documented, nor did she document any efforts to enlist the help of his wife or family to take a repeat test.

C. Respondent's notations concerning the treatments J.F. did receive are lacking in detail and substance. For instance, in May 2006, J.F. received intravenous (IV) infusions of unknown substances, and there is no IV infusion record or clear chart notes that documents the serial infusions or why they were given to the patient, the volume infused, over what timeframe, how the patient tolerated the procedure or the patient's response to each or any of the infusions. Similarly, in June and July 2006, nine (9) acupuncture treatments are listed, but there is no notation regarding the reasons for the visits, the findings, or the response to the treatments. Respondent also does not identify the practitioner who administered the treatments.

D. Except for adequate general examinations at J.F.'s initial visits in 2003 and 2005, respondent has no consistent record of physical examination findings or vital signs taken and recorded. Records are usually sketchy and often illegible.

FIFTH CAUSE FOR DISCIPLINE

(Dishonesty)

50. Respondent has made the following misrepresentations, inconsistent statements, and/or false statements concerning the case before the court:

51. With respect to her treatment of J.F., respondent, in a deposition taken under oath on February 12, 2009 in the civil case which J.F. and S.F. filed against respondent ("civil case"), she indicated the following with respect to J.F.'s November 2005 elevated PSA and any follow up:

(a) She never discussed prostate health with J.F. because, in her mind, she was not his PCP.

(b) She indicated that a PSA of 5.1 had to be followed up but not on an emergency basis. However, she did not do any follow up on J.F.'s elevated PSA and did not recal any discussion with J.F. concerning his PSA elevation.

(c) She indicated that she would have sent J.F. to a urologist for follow up if she would have thought of it. As it was, she indicated, the elevated PSA obviously did not get followed up until "things got where they went."

52. On October 13, 2009, when respondent's deposition in the civil case was completed, respondent indicated the following with respect to J.F.'s November 2005 elevated PSA and any follow up:

(a) She may have discussed urinary function and PSA level with J.F. on November 17, 2005. She did not recall that on any subsequent visit with J.F. discussing urinary function or PSA levels. But it was usual for her to discuss these things with her patients, and she may just not have written it down.

(b) She had no specific recollection of discussing the 5.1 PSA with J.F., or recommending any follow-up, but she must have told him to keep an eye on it and to follow up with her on it.

(c) She did no follow up PSA between November 2005 and June of 2007.

(d) She did not refer J.F. to a urologist.

(e) She never did a digital rectal examination on J.F.

(f) On February 27, 2007, when J.F. presented with chest wall pain, there was no discussion of abnormal labs or PSA.

(g) At the June 1, 2007 visit, respondent recalls J.F. said indicated that after the 182.1 PSA result in Connecticut that he had had a digital rectal examination by a urologist, but he did not want to go for a biopsy, and she facilitated his decision to go for a biopsy.

(h) At the June 1, 2007 visit, respondent recalls that J.F. had been seen at UCSF and that he was told to go for a biopsy by a urologist there.

53. On September 15, 2011, respondent had a physician conference with the Medical Board with medical consultant Peter Tom, M.D. and Medical Board investigator Cathy Lozano. Respondent's attorney, Robert W. Hodges was also present. At that conference, respondent indicated the following with respect to J.F.'s November 2005 abnormal PSA and any follow up:

(a) She had a detailed discussion with J.F. on November 17, 2005 concerning his abnormal labs, including the PSA results. She pointed out his borderline high PSA and explained his risk factors and the possible reasons for the result, that it could be anything from hypertrophy to cancer or maybe a lab error. She indicated that in one or two months, the PSA levels needed to

be checked again. She also advised J.F. to go to his "other doctor" for a digital rectal examination, but that she usually referred patients to a urologist. However, J.F. ignored her advice, as he usually ignored anything medical, preferring alternative healers.

(b) She did not do any urological examination on the November 17, 2005 visit or check the prostate, as he did not have any urinary symptoms.

(c) She reminded J.F. to have the PSA redone and to see a urologist whenever she saw him after that, not just during an appointment. She said J.F. told her he would take care of it but never did.

(d) She told J.F. to get the name of the urologist to whom she referred men at the front desk and make an appointment with him, and he was given a lab slip for a repeat PSA test, but whenever she would check with J.F., he had not gone to the urologist or gotten the PSA done. Neither the lab slip nor an indication of referral to a urologist is in the patient record for J.F.

(e) She says that after the high PSA/alkaline prostate readings in Connecticut in mid-2007, he went to a urologist and that urologist recommended a biopsy, but he refused to go for the biopsy, and at the June 1, 2007 appointment, she had to convince him to go for the biopsy.

(f) She stated that of the 9 or 10 office visits that J.F. had between November 2005 and June of 2007, she discussed his prostate and PSA with him a minimum of three or four times.

(g) She stated that the 5.1 PSA was borderline, a screening thing, and not an emergency, so she did not want to make it a "big deal."

54. Therefore, respondent has exhibited dishonesty substantially related to the practice of medicine when she testified inconsistently at her deposition and then completely changed her representations concerning her follow up on the 5.1 PSA level of November 2005 at her physician conference, blaming J.F.himself for not following her instructions to do a repeat PSA and to go to a urologist and for his refusal to have a biopsy once an extremely high PSA and alkaline phosphatase level was found by the Connecticut laboratory in May 2007.

55. On April 5, 2013, respondent submitted to this court a signed declaration under penalty of perjury that she had retained Monica Stokes, M.D. to be her expert on the K.S. case in April of 2010 and that she had discussed K.S.' treatment with her and had discussed her defenses

to the case. This was at a time when there was no case pending against respondent concerning her treatment of K.S. and the physician conference with the Medical Board concerning K.S. had just taken place. Respondent had no release from K.S. to discuss her treatment with or reveal her medical records to Dr. Stokes.

56. Dr. Stokes was retained to evaluate the K.S. case by the Medical Board more than four months later, and she had no knowledge of the K.S. case. Although she had spoken with respondent in April 2010, Dr. Stokes indicated the conversation concerned Dr. Stokes' activities as a consultant to physicians who were establishing integrative medicine practices, and had nothing to do with a specific patient case or a specific Medical Board investigation. Dr. Stokes indicated that it was mostly a philosophical discussion concerning integrative medicine and its place in the medical community.

57. Respondent has sought by her misrepresentations concerning her April 2010 conversation to disqualify Dr. Stokes as an expert for the Medical Board. In August 2010, the Medical Board was seeking an objective determination as to whether in the K.S. case, respondent met the standards of practice of integrative medicine, and she did provide her unbiased opinion, some of which was favorable to respondent. The Medical Board was not requesting that Dr. Stokes find departures from the standard of practice, but apparently, respondent is indicating that she had solicited an opinion favorable to her in April 2010.

58. The false or misleading statements described above constitute acts of dishonesty substantially related to the practice of medicine, and therefore cause exists for discipline pursuant to section 2234 amd 2234(e) of the Code.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Medical Board of California issue a decision:

1. Revoking or suspending Physician and Surgeon's Certificate Number A67699, issued to Suprabha Jain, M.D.

2. Revoking, suspending or denying approval of Suprabha Jain, M.D.'s authority to supervise physician assistants, pursuant to section 3527 of the Code;

3. Ordering Suprabha Jain, M.D., if placed on probation, to pay to the Medical Board of California the costs of probation monitoring; and

4. Taking such other and further action as deemed necessary and proper.

DATED: 6/14/2013

Vivien N. Hara for

KIMBERLY KIRCHMEYER
Interim Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

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Appendix

Second Amended Accusation Against Suprabha Jain, M.D.

Medical Board of California

Case No. 12 2009 197864

CONCEPTS AND DRUGS INVOLVED

COMPLEMENTARY AND ALTERNATIVE MEDICINE TERMS

1. Ayurvedic Medicine

Background

Ayurvedic medicine, also known as Ayurveda, originated in India several thousand years ago. In the United States, Ayurvedic medicine is considered a type of alternative and complementary medicine and a whole medical system. As with other such systems, it is based on theories of health and illness and on ways to prevent, manage, or treat health problems.

Ayurvedic medicine aims to integrate and balance the body, mind, and spirit. This balance is believed to lead to happiness and health and to help prevent illness. Ayurvedic medicine also treats specific physical and mental health problems. A chief aim of Ayurvedic practices is to cleanse the body of substances that can cause disease, thus helping to reestablish harmony and balance.

Ayurvedic medicine has several key foundations that pertain to health and disease. This concepts have to do with universal interconnectedness, the body's constitution (*pakriti*), and life forces (*doshas*).

Interconnectedness. Ideas about the relationships among people, their health, and the universe form the basis for how Ayurvedic practitioners think about problems that affect health. Ayurvedic medicine holds that:

- All things in the universe (both living and nonliving) are joined together.
- Every human being contains elements that can be found in the universe.
- Health will be good if one's mind and body are in harmony, and one's interaction with the universe is natural and wholesome.
- Disease arises when a person is out of harmony with the universe. Disruptions can be physical, emotional, spiritual, or a combination of these.

Constitution (*Pakriti*). Ayurvedic medicine also has specific beliefs about the body's constitution. Constitution refers to a person's general health, the likelihood of becoming out of balance, and the ability to resist and recover from disease or other health problems.

The constitution is called the *pakriti*. The *pakriti* is a person's unique combination of physical and psychological characteristics and the way the body functions to maintain health. It is influenced by such factors as digestion and how the body deals with waste products. The *pakriti* is believed to be unchanged over a person's lifetime.

Life Forces (*doshas*). Important characteristics of the *pakriti* are the three life forces or energies called *doshas*, which control the activities of the body. A person's chances of developing certain

types of diseases are thought to be related to the way *doshas* are balanced, the state of the physical body, and mental or lifestyle factors.
Ayurvedic medicine holds the following beliefs about the three *doshas*:

- Each *dosha* is made up of two of five basic elements: ether (the upper regions of space), air, fire, water, and earth.
- Each *dosha* has a particular relationship to bodily functions and can be upset for different reasons.
- Each person has a unique combination of the three *doshas*, although one *dosha* is usually prominent. *Doshas* are constantly being formed and reformed by food, activity, and bodily processes.
- Each *dosha* has its own physical and psychological characteristics.
- An imbalance of a *dosha* will produce symptoms that are unique to that *dosha*. Imbalances may be caused by a person's age, unhealthy lifestyle, or diet; too much or too little mental and physical exertion; the seasons; or inadequate protection from the weather, chemicals, or germs.

The *doshas* are known by their original Sanskrit names: *vata*, *pitta*, and *kapha*.

The *vata dosha* combines the elements ether and air. It is considered the most powerful *dosha* because it controls very basic body processes such as cell division, the heart, breathing, discharge of waste, and the mind. *Vata* can be aggravated by, for example, fear, grief, staying up late at night, eating dry fruit, or eating before the previous meal is digested. People with *vata* as their main *dosha* are thought to be especially susceptible to skin and neurological conditions, rheumatoid arthritis, heart disease, anxiety, and insomnia.

The *pitta dosha* represents the elements fire and water. *Pitta* controls hormones and the digestive system. A person with a *pitta* imbalance may experience negative emotions such as anger and may have physical symptoms such as heartburn within 2 or 3 hours of eating. *Pitta* is upset by, for example, eating spicy or sour food, fatigue, or spending too much time in the sun. People with a predominantly *Pitta* constitution are thought to be susceptible to hypertension, heart disease, infectious diseases, and digestive conditions such as Crohn's disease.

The *kapha dosha* combines the elements water and earth. *Kapha* helps to maintain strength and immunity and to control growth. An imbalance of the *kapha dosha* may cause nausea immediately after eating. *Kapha* is aggravated by, for example, greed, sleeping during the daytime, eating too many sweet foods, eating after one is full, and eating and drinking foods and beverages with too much salt and water (especially in the springtime). Those with a predominant *kapha dosha* are thought to be vulnerable to diabetes, cancer, obesity, and respiratory illnesses such as asthma.

Treatment

Ayurvedic treatment is tailored to each person's constitution. Practitioners expect patients to be active participants because many Ayurvedic treatments require changes in diet, lifestyle, and habits.

The patient's *dosha* balance. Ayurvedic practitioners first determine the patient's primary *dosha* and the balance among the three *doshas* by:

- Asking about diet, behavior, lifestyle practices, recent illnesses (including reasons and symptoms), and resilience (ability to recover quickly from illness or setbacks).
- Observing such physical characteristics as teeth and tongue, skin, eyes, weight, and overall appearance.
- Checking the patient's urine, stool, speech and voice, and pulse (each *dosha* is thought to make a particular kind of pulse).

Treatment practices. Ayurvedic treatment goals include eliminating impurities, reducing symptoms, increasing resistance to disease, and reducing worry and increasing harmony in the patient's life. The practitioner uses a variety of methods to achieve these goals:

- **Eliminating impurities.** A process called *panchakarma* is intended to cleanse the body by eliminating *ama*. *Ama* is described as an undigested food that sticks to the tissues, interferes with normal functioning of the body, and leads to disease. *Panchakarma* focuses on eliminating *ama* through the digestive tract and the respiratory system. Enemas, massage, medical oils administered as a nasal spray, and other methods may be used.
- **Reducing symptoms.** The practitioner may suggest various options, including physical exercises, stretching, breathing exercises, meditation, massage, lying in the sun, and changing the diet. The patient may take certain herbs – often with honey, to make them easier to digest. Sometimes diets are restricted to certain foods. Very small amounts of metal and mineral preparations, such as gold or iron, also may be given.
- **Increasing resistance to disease.** The practitioner may combine several herbs, proteins, minerals, and vitamins in tonics to improve digestion and increase appetite and immunity. These tonics are based on formulas from ancient texts.
- **Reducing worry and increasing harmony.** Ayurvedic medicine emphasizes mental nurturing and spiritual healing. Practitioners may recommend avoiding situations that cause worry and using techniques that promote release of negative emotions.

Use of plants. Ayurvedic treatments rely heavily on herbs and other plants – including oils and common spices. Currently, more than 600 herbal formulas and 250 single plant drugs are included in the "pharmacy" of Ayurvedic treatments. Historically, Ayurvedic medicine has grouped plant compounds into categories according to their effects (for example, healing, promoting vitality, or relieving pain). The compounds are described in texts issued by national medical agencies in India. Sometimes, botanicals are mixed with metals or other naturally occurring substances to make formulas prepared according to specific Ayurvedic text procedures; such preparations involve several herbs and herbal extracts and precise heat treatments.

Practitioner Training and Certification

Many practitioners study in India, where there are more than 150 undergraduate and 30 postgraduate colleges for Ayurvedic medicine. Training can take 5 years or longer. Students who receive their Ayurvedic training in India can earn either a bachelor's degree (Bachelor of Ayurvedic Medicine and Surgery, BAMS) or doctoral degree (Doctor of Ayurvedic Medicine and Surgery, DAMS) there. After graduation, some Ayurvedic practitioners choose to provide services in the United States or other countries.

The United States has no national standard for training or certifying Ayurvedic practitioners, although a few states, including California, have approved Ayurvedic schools and educational institutions.

(Taken from: U.S. Department of Health and Human Services (in conjunction with the National Institutes of Health(NIH), National Center for Complementary and Alternative Medicine (NCCAM), *Backgrounder – Ayurvedic Medicine: An Introduction* (National Library of Medicine, PubMed: created October 2005, updated July 2009).

2. Chelation Therapy

Chelation therapy is the administration of chelating agents to remove heavy metals from the body. The use of ethylenediaminetetraacetic acid (EDTA) as a chelating agent is only approved by the FDA for the removal of lead in cases of acute lead poisoning. The drug binds to heavy metals in the body to prevent them from binding with other agents, and they are then excreted from the body. The chelating process also removes vital nutrients such as vitamins C and E. Side effects of chelation therapy, even when used at FDA approved doses are low, but include fever, headache, nausea, stomach upset, vomiting, convulsions, bone marrow depression, hypotension, cardiac arrhythmias, respiratory arrest, and hypocalcemia. Other concerns are kidney failure or death.

Alternative medicine practitioners may use EDTA chelation therapy as a non-standard treatment for some conditions, including heart disease and autism, and some have attempted to use it for treatment of kidney dysfunction, atherosclerosis and cancer. There is currently no scientific support for its efficacy in the treatment of any of these disorders. The National Center for Complementary and Alternative Medicine (NCCAM) acknowledged in 2002 that more serious side effects may occur when EDTA is not administered by a health professional for the treatment of heavy metal poisoning. (NCCAM, "Questions and Answers: The NIH Trail of EDTA Chelation Therapy for Coronary Artery Disease," *NCCAM/NIH News*, 2002).

3. Colonic Irrigation

Colonic irrigation involves cleansing the colon by using special equipment to pass water through it. This involves the cleansing of the entire large intestine, not just the lower bowel. In traditional Western medicine, colon cleansing is usually done only in conjunction with

preparation for colonoscopy, but many alternative medicine practitioners believe that colon cleansing is essential in the prevention and treatment of degenerative diseases.

Colon hydrotherapy treatment is premised on the belief that over time, many people develop a layer of fecal matter coating their colons, sometimes even causing total obstruction. Incomplete elimination of body wastes, depending on where the deposits are located, may result in arthritis, IBS, diverticulitis, Crohn's Disease, heart problems, migraines, allergies, asthma, dementia, chronic fatigue syndrome, multiple sclerosis, and even cancer, particularly of the bowel. Colon cleansing eliminates this built-up waste and the toxins created by it, thereby alleviating or preventing the development of these disease states or medical conditions.

During colonic irrigation, a small speculum is passed into the patient's bowel through the rectum, and this is attached to a tube. The tube is attached to a machine that pumps body-temperature water into the colon at a controlled rate. The amount of water pumped is from two to six quarts. Peristaltic action expels the water and the waste matter back through the tube and into the machine, where it is monitored.

The FDA regulates the production of equipment used in colon hydrotherapy in the USA, but does not regulate their use or any supplements used in the cleansing regimens.

4. Dark Field Microscopy

Dark field microscopy involves a very bright light source, such as a halogen light, with an intervening dark field condenser on top. Only light that is reflected, refracted, or diffracted by the specimen enters the objective. The result is an oblique illumination of the specimen, revealing an attractive and detailed view of the specimen. This is useful to enhance contrast in unstained specimens.

Although not in widespread use among integrative medical physicians, dark field microscopy is used by some for live blood analysis, an examination of live blood cells *in vitro* through the use of dark field microscopy. Proponents claim this provides information about immune system deficiencies, vitamin and mineral imbalances, fungus and yeast presence, and weakness in vital organs. Although there are some studies finding live blood analysis useful for potential detection of malaria, there is no scientific evidence of its efficacy in diagnosing the other deficiencies or disease states.

Dr. Andrew Weil, a well-know proponent of alternative medicine, dismissed live blood cell analysis by stating, "Dark-field microscopy combined with live-blood analysis may sound like cutting edge science, but it's old-fashioned hokum. Don't buy into it." (Andrew Weil, M.D., "Ask Dr. Weil," *Arizona Daily* Star, September 11, 2007.)

5. Libidex Cream

Libidex Cream is a 14% acqueous exfoliation gel and a natural tarnsdermal endocrine cream indicated for the treatment of stress-induced hormonal and emotional imbalances.

6. Meyers' (or Myers') Cocktail

Myers' cocktail is an intravenous nutrient cocktail therapy introduced by John Myers, M.D. of Baltimore, Maryland in the 1950's. The cocktail consists of magnesium chloride, calcium gluconate, Vitamin B-12, Vitamin B-6, Vitamin B-5, Vitamin B complex, and Vitamin C. These are nutrients that are found to be deficient in a number of pathologies. This therapy has been administered most recently to boost energy and promote a sense of well-being. It has been used in the treatment of respiratory symptoms of asthma, upper respiratory infections, sinusitis, allergic rhinitis, migraine pain, fibromyalgia, and even chronic fatigue syndrome and cardiovascular disease. There is no scientific evidence of its usefulness in the treatment of any of these conditions, except that one study showed improvement in fibromyalgia symptoms, but this study was contradicted by another placebo-controlled study showed no significant benefit over placebo.

DANGEROUS DRUGS INVOLVED

1. **Abilify**, a trade name for aripiprizole, is a dangerous drug, as defined in Business and Professions Code section 4022 ("section 4022") and is indicated for the treatment of adults with schizophrenia or with manic or mixed episodes associated with Bipolar I disorder. It is also indicated as an adjunct treatment for adults with major depressive disorder. It must be used with caution in patients with risk factors for diabetes, such as obesity, and blood sugar levels should be monitored. Warnings indicate that the drug may affect judgment, thinking, or motor skills.

2. **Advair**, a trade name for an inhalation product containing a combination of fluticasone proprionate and salmeterol is indicated for the treatment of long-term maintenance treatment of asthma and chronic obstructive pulmonary disease. It is a dangerous drug, as defined in section 4022.

3. **Albuterol sulfate** is a beta-2 adrenergic agonist indicated for the treatment or prevention of bronchospasm in patients with reversible obstructive airway disease or with exercise-induced bronchospasm. It is a dangerous drug as defined in section 4022.

4. **Dilaudid**, a trade name for hydromorphone hydrochloride, is a hydrogenated ketone of morphine and a narcotic analgesic. Its principal therapeutic use is relief of pain. Psychic dependence and tolerance may develop upon repeated administration of narcotics, and therefore Dilaudid should be prescribed and administered with caution. Physical dependence, the condition in which continued administration of the drug is required to prevent the appearance of a withdrawal syndrome, usually assumes clinically significant proportions after several weeks of continued use. Side effects include drowsiness, mental clouding, respiratory depression, and vomiting. Dilaudid is a dangerous drug as defined in section 4022 and a Schedule II controlled substance under Health and Safety Code section 11055(b)(1)(K).

5. **Effexor**, a trade name for venlafaxine hydrochloride, is indicated for the treatment of depression. It is a dangerous drug as defined in section 4022.

6. **Duragesic Patches (aka Fentanyl Patches)**, a trade name for a fentanyl transdermal system, contain fentanyl, an opioid analgesic, the primary effects of which are anesthesia and sedation. Fentanyl is a strong opioid medication and is indicated only for treatment of severe chronic pain (such as that of malignancy) that cannot be managed by lesser means and requires continuous opioid administration. Fentanyl presents a risk of serious or life-threatening hypoventilation. When patients are receiving fentanyl, the dosage of central nervous system (CNS) depressant drugs should be reduced at least 50%. Use of fentanyl together with other CNS depressants, including alcohol, can result in increased risk to the patient. It should be used with caution in patients with a history of alcohol or drug abuse, particularly if they are outside of a medically controlled environment. Fentanyl can produce drug dependence similar to that produced by morphine and has the potential for abuse. Fentanyl is a dangerous drug as defined in section 4022 and a Schedule II controlled substance under Health and Safety Code section 11055(c)(8).

7. **Klonopin**, a trade name for clonazepam, is an anticonvulsant of the benzodiazepine class of drugs. It is indicated for the treatment of a certain class of petit mal seizures and of panic disorder. Klonopin produces central nervous system depression and should be used with caution with other CNS depressant drugs. Like other benzodiazepines, it can produce psychological and physical dependence. Withdrawal symptoms similar to those noted with barbiturates and alcohol have been noted upon abrupt discontinuance of Klonopin. Klonopin is a dangerous drug as defined in section 4022 and a Schedule IV controlled substance under Health and Safety Code section 11057(d)(7).

8. **Oxycodone**, usually compounded with acetaminophen or aspirin, is a semisynthetic narcotic derived from the opium alkaloid thebaine, with multiple actions quantitatively similar to those of morphine. It is an opioid agonist indicated for the treatment of moderate to severe pain. Oxycodone can produce drug dependence of the morphine type and therefore has the potential for being abused. Oxycodone is a dangerous drug under sectin 4022 and a Schedule II controlled substance under Health and Safety Code section 11055(b)(1)(N).

9. **Xanax** is a trade name for alprazolam tablets. Alprazolam is a psychotropic triazolo analogue of the 1,4 benzodiazepine class of central nervous system-active compounds. Xanax is used for the management of anxiety disorders or for the short-term relief of the symptoms of anxiety. It is a dangerous drug as defined in section 4022 and a schedule IV controlled substance and narcotic under Health and Safety Code section 11057(d)(1). Xanax has a central nervous system depressant effect and patients should be cautioned about the simultaneous ingestion of alcohol and other CNS depressant drugs during treatment with Xanax. Addiction-prone individuals (such as drug addicts or alcoholics) should be under careful surveillance when receiving alprazolam because of the predisposition of such patients to habituation and dependence.